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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 600

[CMS-2441-F]

RIN 0938-AU89

Basic Health Program; Federal Funding Methodology for Program Year 2023 and Changes to the Basic Health Program Payment Notice Process

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

ACTION: Final rule.

SUMMARY: This rule finalizes the methodology and data sources necessary to determine Federal payment amounts to be made for program year 2023 to States that elect to establish a Basic Health Program under the Patient Protection and Affordable Care Act to offer health benefits coverage to low-income individuals otherwise eligible to purchase coverage through Health Insurance Exchanges.

DATES: This amendments in this rule are effective January 1, 2023. The methodology and data sources announced in this rule are effective on January 1, 2023.

FOR FURTHER INFORMATION CONTACT: Christopher Truffer, (410) 786-1264; or Cassandra Lagorio, (410) 786-4554.

SUPPLEMENTARY INFORMATION:

I. Background

A. Overview of the Basic Health Program

Section 1331 of the Patient Protection and Affordable Care Act (Pub. L. 111-148, enacted March 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152, enacted March 30, 2010) (collectively referred to as the Affordable Care Act

or ACA), provides States with an option to establish a Basic Health Program (BHP). In the States that elect to operate a BHP, the BHP makes affordable health benefits coverage available for individuals under age 65 with household incomes between 133 percent and 200 percent of the Federal poverty level (FPL) who are not otherwise eligible for Medicaid, the Children's Health Insurance Program (CHIP), or affordable employer-sponsored coverage, or for individuals whose income is below these levels but are lawfully present non-citizens ineligible for Medicaid. For those States that have expanded Medicaid coverage under section 1902(a)(10)(A)(i)(VIII) of the Social Security Act (the Act), the lower income threshold for BHP eligibility is effectively 138 percent due to the application of a required 5 percent income disregard in determining the upper limits of Medicaid income eligibility (section 1902(e)(14)(I) of the Act).

A BHP is another option for States to provide affordable health benefits to individuals with incomes in the ranges described above. States may find a BHP a useful option for several reasons, including the ability to potentially coordinate standard health plans in the BHP with their Medicaid managed care plans, or to potentially reduce the costs to individuals by lowering premiums or cost-sharing requirements.

Federal funding for a BHP under section 1331(d)(3)(A) of the ACA is based on the amount of the Federal premium tax credit (PTC) allowed and payments to cover required cost-sharing reductions (CSRs) that would have been provided for the fiscal year to eligible individuals enrolled in BHP standard health plans in the State if such eligible individuals were allowed to enroll in a qualified health plan (QHP) through Health Insurance Exchanges (Exchanges). These funds are paid to trusts established by the States and dedicated to the BHP, and the States then administer the payments to standard health plans within the BHP.

In the March 12, 2014, **Federal Register** (79 FR 14111), we published a final rule entitled "Basic Health Program: State Administration of Basic Health Programs; Eligibility and Enrollment in Standard Health Plans; Essential Health Benefits in Standard Health Plans; Performance Standards for Basic Health Programs; Premium and Cost Sharing for Basic Health

Programs; Federal Funding Process; Trust Fund and Financial Integrity" (hereinafter referred to as the BHP final rule), implementing section 1331 of the ACA, which governs the establishment of BHPs. The BHP final rule established the standards for State and Federal administration of BHPs, including provisions regarding eligibility and enrollment, benefits, cost-sharing requirements and oversight activities. While the BHP final rule codified the overall statutory requirements and basic procedural framework for the funding methodology, it does not contain the specific information necessary to determine Federal payments. We anticipated that the methodology would be based on data and assumptions that would reflect ongoing operations and experience of BHPs, as well as the operation of the Exchanges. For this reason, the BHP final rule indicated that the development and publication of the funding methodology, including any data sources, would be addressed in a separate annual BHP Payment Notice.

In the BHP final rule, we specified that the BHP Payment Notice process would include the annual publication of both a proposed and final BHP payment methodology. The proposed BHP Payment Notice would be published in the **Federal Register** each October, 2 years prior to the applicable program year, and would describe the proposed funding methodology for the relevant BHP year,[1] including how the Secretary of the Department of Health and Human Services (the Secretary) considered the factors specified in section 1331(d)(3) of the ACA, along with the proposed data sources used to determine the Federal BHP payment rates for the applicable program year. The final BHP Payment Notice would be published in the **Federal Register** in February, and would include the final BHP payment methodology, as well as the Federal BHP payment rates for the applicable BHP program year. For example, payment rates in the final BHP Payment Notice published in February 2015 applied to BHP program year 2016, beginning in January 2016. As discussed in section II.D. of this final rule, and as referenced in 42 CFR 600.610(b)(2), State data needed to calculate the Federal BHP payment rates for the final BHP Payment Notice must be submitted to CMS.

[1] BHP program years span from January 1 through December 31.

In the 2023 BHP proposed rule, we proposed to revise the schedule for issuance of payment notices and allow payment notices to be effective for 1 or multiple program years, as determined by and subject to the discretion of the Secretary, beginning with the 2023 BHP payment methodology. As discussed in section IV. of this final rule, we are finalizing this proposal. Thus, the payment methodology described in this final rule will be in effect until CMS proposes a new payment methodology.

As described in the BHP final rule, once the final rule for the applicable program year has been published, we will generally make modifications to the BHP funding methodology on a prospective basis, with limited exceptions. The BHP final rule provided that retrospective adjustments to the State's BHP payment amount may occur to the extent that the prevailing BHP funding methodology for a given program year permits adjustments to a State's Federal BHP payment amount due to insufficient data for prospective determination of the relevant factors specified in the applicable final BHP Payment Notice. For example, the population health factor adjustment described in section III.D.3. of this final rule allows for a retrospective adjustment (at the State's option) to account for the impact that BHP may have had on the risk pool and QHP premiums in the Exchange. Additional adjustments could be made to the payment rates to correct errors in applying the methodology (such as mathematical errors).

Under section 1331(d)(3)(ii) of the ACA, the funding methodology and payment rates are expressed as an amount per eligible individual enrolled in a BHP standard health plan (BHP enrollee) for each month of enrollment. These payment rates may vary based on categories or classes of enrollees. Actual payment to a State would depend on the actual enrollment of individuals found eligible in accordance with a State's certified BHP Blueprint eligibility and verification methodologies in coverage through the State BHP. A State that is approved to implement a BHP must provide data showing quarterly enrollment of eligible individuals in the various Federal BHP payment rate cells. Such data must include the following:

- Personal identifier;

- Date of birth;
- County of residence;
- Indian status;
- Family size;
- Household income;
- Number of persons in household enrolled in BHP;
- Family identifier;
- Months of coverage;
- Plan information; and
- Any other data required by CMS to properly calculate the payment.

B. The 2018 Final Administrative Order and 2019 through 2022 Payment Methodologies

On October 11, 2017, the Attorney General of the United States provided the Department of Health and Human Services and the Department of the Treasury (the Departments) with a legal opinion indicating that the permanent appropriation at 31 U.S.C. 1324, from which the Departments had historically drawn funds to make CSR payments, cannot be used to fund CSR payments to insurers. In light of this opinion – and in the absence of any other appropriation that could be used to fund CSR payments – the Department of Health and Human Services directed CMS to discontinue CSR payments to issuers until Congress provides for an appropriation. In the absence of a Congressional appropriation for Federal funding for CSR payments, we cannot provide States with a Federal payment attributable to CSRs that would have been paid on behalf of BHP enrollees had they been enrolled in a QHP through an Exchange.

Starting with the payment for the first quarter (Q1) of 2018 (which began on January 1, 2018), we stopped paying the CSR component of the quarterly BHP payments to New York and Minnesota (the States), the only States operating a BHP in 2018. The States then sued the Secretary for declaratory and injunctive relief in the United States District Court for the Southern District of New York. *See New York v. U.S. Dep't of Health & Human Servs.*, No. 18-cv-00683

(RJS) (S.D.N.Y. filed Jan. 26, 2018). On May 2, 2018, the parties filed a stipulation requesting a stay of the litigation so that HHS could issue an administrative order revising the 2018 BHP payment methodology. As a result of the stipulation, the court dismissed the BHP litigation. On July 6, 2018, we issued a Draft Administrative Order on which New York and Minnesota had an opportunity to comment. Each State submitted comments. We considered the States' comments and issued a Final Administrative Order on August 24, 2018[2] (Final Administrative Order) setting forth the payment methodology that would apply to the 2018 BHP program year.

In the November 5, 2019 **Federal Register** (84 FR 59529) (hereinafter referred to as the November 2019 final BHP Payment Notice), we finalized the payment methodologies for BHP program years 2019 and 2020. The 2019 payment methodology is the same payment methodology described in the Final Administrative Order. The 2020 payment methodology is the same methodology as the 2019 payment methodology with one additional adjustment to account for the impact of individuals selecting different metal tier level plans in the Exchange, referred to as the Metal Tier Selection Factor (MTSF).[3] In the August 13, 2020 **Federal Register** (85 FR 49264 through 49280) (hereinafter referred to as the August 2020 final BHP Payment Notice), we finalized the payment methodology for BHP program year 2021. The 2021 payment methodology is the same methodology as the 2020 payment methodology, with one adjustment to the income reconciliation factor (IRF). In the July 7, 2021 **Federal Register** (86 FR 35615) (hereinafter referred to as the July 2021 final BHP Payment Notice), we finalized the payment methodology for BHP program year 2022. The 2022 payment methodology is the same as the 2021 payment methodology, which the exception of the removal of the MTSF. The 2023 payment methodology is the same as the 2022 payment methodology, except for the addition of a factor to account for a State operating a BHP and implementing an approved State

[2] https://www.medicaid.gov/sites/default/files/2019-11/final-admin-order-2018-revised-payment-methodology.pdf.
[3] "Metal tiers" refer to the different actuarial value plan levels offered on the Exchanges. Bronze-level plans generally must provide 60 percent actuarial value; silver-level 70 percent actuarial value; gold-level 80 percent actuarial value; and platinum-level 90 percent actuarial value. See 45 CFR 156.140.

Innovation Waiver under section 1332 of the ACA (referred to as a section 1332 waiver throughout this final payment methodology).

II. Summary of the Proposed Provisions and Analysis of and Responses to the Public Comments

In the May 25, 2022 **Federal Register** (87 FR 31815 through 31833), we published the "Federal Funding Methodology for Program Year 2023 and Proposed Changes to Basic Health Program Regulations" proposed rule (hereinafter referred to as the 2023 BHP proposed rule).

We received 7 timely public comments from individuals and organizations, including, but not limited to, State government agencies, other government agencies, and private citizens. In this section, we provide a summary of the provisions of the 2023 BHP proposed rule and the public comments and our responses.

A. Background

In the 2023 BHP proposed rule, we proposed the methodology for how the Federal BHP payments would be calculated for program year 2023 and subsequent years until a new payment methodology is proposed and finalized, in accordance with the policy finalized in section IV of this final rule.

We received the following comments on the background information included in the 2023 BHP proposed rule.

Comment: Several commenters were supportive of the 2023 BHP payment methodology described in the 2023 BHP proposed rule.

Response: We appreciate the support from these commenters. As described further in this final rule, we are finalizing the 2023 methodology as proposed in the 2023 BHP proposed rule.

Comment: One commenter suggested caution regarding the adoption of BHP in new States, as the establishment of a BHP could impact affordability for individuals who remain in Marketplace coverage. Specifically, the commenter noted that adoption of a BHP could result in

a loss in overall enrollment in the individual market, higher premiums for consumers with incomes above 200 percent FPL who remain in the individual market, and a potential reduction in plan choices.

Response: We appreciate the comment. We believe that States should consider how a BHP would impact coverage and affordability for State residents as part of its decision to start a BHP.

B. Overview of the Funding Methodology and Calculation of the Payment Amount

In the 2023 BHP proposed rule, we proposed in the overview of the funding methodology to calculate the PTC and CSR as consistently as possible and in general alignment with the methodology used by Exchanges to calculate the advance payments of the PTC (APTC) and CSR, and by the Internal Revenue Service (IRS) to calculate the allowable PTC. We proposed four equations that would, if finalized, compose the overall BHP payment methodology. For specific discussions of these proposals, please refer to the 2023 BHP proposed rule (87 FR 31817 through 31819).

We received no comments on the overview of the funding methodology included in the 2023 BHP proposed rule. Therefore, we are finalizing these policies as proposed.

C. Federal BHP Payment Rate Cells

In the 2023 BHP proposed rule, we proposed to continue to require that a State implementing BHP provide us with an estimate of the number of BHP enrollees it will enroll in the upcoming BHP program quarter, by applicable rate cell, to determine the Federal BHP payment amounts. For each State, we proposed using rate cells that separate the BHP population into separate cells based on the following factors: age, geographic rating area, coverage status, household size, and income. For specific discussions of these proposals, please refer to the 2023 BHP proposed rule (87 FR 31819 through 31820).

We received no comments on this aspect of the proposed methodology. Therefore, we are finalizing these policies as proposed.

D. Sources and State Data Considerations

In the 2023 BHP proposed rule, we proposed to continue to use, to the extent possible, data submitted to the Federal Government by QHP issuers seeking to offer coverage through an Exchange that uses HealthCare.gov to determine the Federal BHP payment cell rates. However, for States operating a State-based Exchange (SBE), which do not use HealthCare.gov, we proposed to continue to require such States to submit required data for CMS to calculate the Federal BHP payment rates in those States. For specific discussions, please refer to the 2023 BHP proposed rule (87 FR 31820 through 31821).

We received no comments on this aspect of the proposed methodology. Therefore, we are finalizing these policies as proposed.

E. Discussion of Specific Variables Used in Payment Equations

In the 2023 BHP proposed rule, we proposed to use eight specific variables in the payment equations that compose the overall BHP funding methodology:

- Reference Premium (RP)
- Premium Adjustment Factor (PAF)
- Population Health Factor (PHF)
- Household Income (I)
- Premium Tax Credit Formula (PTCF)
- Income Reconciliation Factor (IRF)
- Premium Trend Factor (PTF)
- Section 1332 Waiver Factor (WF)

For each proposed variable, we included a discussion on the assumptions and data sources used in developing the variables. We proposed to include a new factor, the WF, to account for a State operating a BHP and implementing an approved section 1332 waiver. For specific discussions, please refer to 2023 BHP proposed rule (87 FR 31821 through 31826).

Below is a summary of the public comments we received regarding specific factors and

our response.

Comment: Several commenters were supportive of the inclusion of the WF in the payment methodology. Specifically, commenters noted this factor will result in more equitable funding for States that have chosen to operate a BHP as well as a reinsurance program under section 1332 of the ACA.

Response: We appreciate the support from these commenters. After consideration of comments, we are finalizing the inclusion of the WF in the payment methodology as proposed.

F. State Option to Use Prior Program Year QHP Premiums for BHP Payments

In the 2023 BHP proposed rule, we proposed to continue to provide States operating a BHP with the option to use the 2022 QHP premiums multiplied by a premium trend factor to calculate the Federal BHP payment rates instead of using the 2023 QHP premiums. We proposed to require States to make their election for the 2023 program year within 60 days of publication of the final payment methodology. For specific discussions, please refer to the 2023 BHP proposed rule (87 FR 31827).

We received no comments on this aspect of the proposed methodology. Therefore, we are finalizing these policies as proposed.

G. State Option to Include Retrospective State-Specific Health Risk Adjustment in Certified Methodology

In the 2023 BHP proposed rule, we proposed to provide States implementing BHP the option to develop a methodology to account for the impact that including the BHP population in the Exchange would have had on QHP premiums based on any differences in health status between the BHP population and persons enrolled through the Exchange. We proposed that States would submit their optional protocol to CMS by the later of August 1, 2022, or 60 days after the publication of the final rule. We proposed that CMS would approve the protocol by December 31, 2022. For specific discussions, please refer to the 2023 BHP proposed rule (87 FR 31827 through 31828).

We received no comments on this aspect of the methodology. Therefore, we are finalizing this policy as proposed, with one modification to the date by which CMS will approve the protocol. Because we are finalizing the 2023 payment methodology after August 1, 2022, a State electing this option must submit its operational protocol to CMS within 60 days of publication of this final rule. Because December 31, 2022, falls within 60 days of publication of this final rule, we are finalizing that CMS will review and approve the State's protocol within 60 days of receipt of the proposed protocol.

H. Revisions to Basic Health Program Regulations

In the 2023 BHP proposed rule, we proposed two changes related to the timing of publication of the BHP payment methodologies and correcting payment errors in § 600.610 (87 FR 31828 through 31829). Specifically, we proposed to revise § 600.610(a)(1) to provide for issuance of payment methodology that may be effective for only 1 or multiple program years, as determined by and subject to the discretion of the Secretary, beginning with the 2023 BHP payment methodology and then going forward. In addition, we proposed at § 600.610(a)(1) and (b)(1) to change the schedule of publication dates for the proposed and final BHP payment methodologies. We also proposed changes to § 600.610(c)(2)(ii) to allow retroactive adjustments to a State's payment if the payment was a result of an error in the application of the payment methodology, which would allow CMS to correct payments made to States in 2019 that were based on an incorrect value for the income reconciliation factor.

Below is a summary of the public comments we received regarding these proposals and our responses.

Comment: Many commenters expressed support for the regulatory changes. Specifically, one commenter noted that allowing the payment methodology to apply to multiple years will reduce administrative burden when there are no changes to the proposed payment methodology.

Response: We appreciate the support from these commenters. As described further in this final rule, we are finalizing the regulations as proposed.

Comment: One commenter requested clarification regarding how CMS will notify States of the annual deadlines for electing to use the current year's Marketplace premiums or the previous year's Marketplace premiums (multiplied by a trend factor) for purposes of calculating BHP payments and submitting an optional risk adjustment protocol.

Response: To maintain consistency with the deadlines established for making these elections for previous program years, States will have until the later of May 15 of the year preceding the applicable program year or 30 days from the release of the subregulatory guidance to elect to use the current year's Marketplace premiums or the previous year's Marketplace premiums (multiplied by a trend factor) for purposes of calculating Federal BHP payments. States will have until the later of August 1 of the year preceding the applicable program year or 30 days from the release of the subregulatory guidance to submit an optional risk adjustment protocol. These dates will be included in the subregulatory guidance CMS issues.

Comment: One commenter requested that CMS issue subregulatory guidance updating the values of factors needed to calculate Federal BHP payments by January of the year preceding the applicable benefit year.

Response: We are unable to carry out the commenter's request because the value of the factors may not be available in time to publish subregulatory guidance annually in January. We anticipate releasing subregulatory guidance in the Spring of the year preceding the applicable benefit year to the extent possible. As discussed previously in this final rule, States will have until the later of May 15 of the year preceding the applicable program year or 30 days from the release of the subregulatory guidance to elect to use the current year's Marketplace premiums or the previous year's Marketplace premiums (multiplied by a trend factor) for purposes of calculating Federal BHP payments.

Comment: One commenter supported the proposed regulation change that would allow CMS to correct the 2019 payments to States that were calculated based on an incorrect value for the income reconciliation factor.

Response: We appreciate the support and are finalizing these regulation changes as proposed, with minor formatting edits. Specifically, we are separating revised § 600.610(a)(1) into § 600.610(a)(1)(i) and (ii) for improved clarity.

After consideration of public comments received, we are finalizing these regulation changes as proposed.

III. Provisions of the 2023 BHP Payment Methodology

A. Overview of the Funding Methodology and Calculation of the Payment Amount

Section 1331(d)(3) of the ACA directs the Secretary to consider several factors when determining the Federal BHP payment amount, which, as specified in the statute, must equal 95 percent of the value of the PTC allowed and CSRs that would have been paid on behalf of BHP enrollees had they enrolled in a QHP through an Exchange. Thus, the BHP funding methodology is designed to calculate the PTC and CSRs as consistently as possible and in general alignment with the methodology used by Exchanges to calculate advance payments of the PTC (APTC) and CSRs, and the methodology used to calculate PTC under 26 U.S.C. 36B, for the tax year. In general, we have relied on values for factors in the payment methodology specified in statute or other regulations, as available, and have developed values for other factors not otherwise specified in statute, or previously calculated in other regulations, to simulate the values of the PTC allowed and CSRs that would have been paid on behalf of BHP enrollees if they had enrolled in QHPs offered through an Exchange. In accordance with section 1331(d)(3)(A)(iii) of the ACA, the final funding methodology must be certified by the Chief Actuary of CMS, in consultation with the Office of Tax Analysis (OTA) of the Department of the Treasury, as having met the requirements of section 1331(d)(3)(A)(ii) of the ACA.

Section 1331(d)(3)(A)(ii) of the ACA specifies that the payment determination shall take into account all relevant factors necessary to determine the value of the PTC allowed and CSRs that would have been paid on behalf of eligible individuals, including but not limited to, the age and income of the enrollee, whether the enrollment is for self-only or family coverage,

geographic differences in average spending for health care across rating areas, the health status of the enrollee for purposes of determining risk adjustment payments and reinsurance payments that would have been made if the enrollee had enrolled in a QHP through an Exchange, and whether any reconciliation of APTC and CSR would have occurred if the enrollee had been so enrolled. Under all previous payment methodologies, the total Federal BHP payment amount has been calculated using multiple rate cells in each State. Each rate cell represents a unique combination of age range (if applicable),[4] geographic area, coverage category (for example, self-only or two-adult coverage through the BHP), household size, and income range as a percentage of FPL, and there is a distinct rate cell for individuals in each coverage category within a particular age range who reside in a specific geographic area and are in households of the same size and income range. The BHP payment rates developed also are consistent with the State's rules on age rating. Thus, in the case of a State that does not use age as a rating factor on an Exchange, the BHP payment rates would not vary by age.

Under the methodology finalized in the July 2021 final BHP Payment Notice, the rate for each rate cell is calculated in two parts. The first part is equal to 95 percent of the estimated PTC that would have been allowed if a BHP enrollee in that rate cell had instead enrolled in a QHP in an Exchange. The second part is equal to 95 percent of the estimated CSR payment that would have been made if a BHP enrollee in that rate cell had instead enrolled in a QHP in an Exchange. These two parts are added together and the total rate for that rate cell would be equal to the sum of the PTC and CSR rates. As noted in the July 2021 final BHP Payment Notice, we currently assign a value of zero to the CSR portion of the BHP payment rate calculation, because there is presently no available appropriation from which we can make the CSR portion of any BHP payment.

We note that throughout this final rule, when we refer to enrollees and enrollment data,

[4] In the case of a State that does not use age as a rating factor on an Exchange, the BHP payment rates would not vary by age.

we mean data regarding individuals who are enrolled in the BHP who have been found eligible for the BHP using the eligibility and verification requirements that are applicable in the State's most recent certified Blueprint. By applying the equations separately to rate cells based on age (if applicable), income and other factors, we effectively take those factors into account in the calculation. In addition, the equations reflect the estimated experience of individuals in each rate cell if enrolled in coverage through an Exchange, taking into account additional relevant variables. Each of the variables in the equations is defined in this section, and further detail is provided later in this section of this final rule.

As noted in section II.B. of this final rule, we proposed four equations, which we are finalizing as proposed, that would compose the overall BHP payment methodology. Equation (1) will be used to calculate the estimated PTC for eligible individuals enrolled in the BHP in each rate cell. Equation (2a) and Equation (2b) will be used to calculate the adjusted reference premium that is used in Equation (1). Equation (3) will determine the total monthly payment by rate cell.

Equation 1: Estimated PTC by rate cell

We are finalizing, as proposed, that estimated PTC per enrollee will be calculated for each rate cell for each State based on age range (if applicable), geographic area, coverage category, household size, and income range. The PTC portion of the rate will be calculated in a manner consistent with the methodology used to calculate the PTC for persons enrolled in a QHP as defined in 26 CFR 1.36B-3, with five adjustments. First, the PTC portion of the rate for each rate cell will represent the mean, or average, expected PTC that all persons in the rate cell would receive, rather than being calculated for each individual enrollee. Second, the reference premium (RP) (described in section III.D.1. of this final rule) used to calculate the PTC will be adjusted for the BHP population health status. In the case of a State that elects to use 2022 premiums for the basis of the BHP Federal payment, the RP also will be adjusted for the projected change in the premium from 2022 to 2023. These adjustments are described in Equation (2a) and Equation

(2b). Third, the PTC will be adjusted prospectively to reflect the average net expected impact of income reconciliation for individuals receiving APTC in the Exchange on the combination of all persons enrolled in the BHP; this adjustment, the IRF, which is described in section III.D.7. of this final rule, will account for the impact on the PTC that would have occurred had such reconciliation been performed. Finally, the rate is multiplied by 95 percent, consistent with section 1331(d)(3)(A)(i) of the ACA. We note that in the situation where the average income contribution of an enrollee would exceed the adjusted reference premium, we will calculate the PTC to be equal to 0 and would not allow the value of the PTC to be negative.

Consistent with the methodology described above, Equation (1), used to calculate the PTC portion of the BHP payment for each rate cell, is finalized as follows:

$$\textbf{Equation (1): } PTC_{a,g,c,h,i} = \left[ARP_{a,g,c} - \frac{\sum_j I_{h,i,j} \times PTCF_{h,i,j}}{n} \right] \times IRF \times 95\%$$

$PTC_{a,g,c,h,i}$ = Premium tax credit portion of BHP payment rate

a = Age range

g = Geographic area

c = Coverage status (self-only or applicable category of family coverage) obtained through BHP

h = Household size

i = Income range (as percentage of FPL)

$ARP_{a,g,c}$ = Adjusted reference premium

$I_{h,i,j}$ = Income (in dollars per month) at each 1 percentage-point increment of FPL

$j = j^{th}$ percentage-point increment FPL

n = Number of income increments used to calculate the mean PTC

$PTCF_{h,i,j}$ = Premium tax credit formula percentage

IRF = Income reconciliation factor

Equation (2a) and Equation (2b): Adjusted Reference Premium Variable (used in Equation 1)

As part of the calculations for the PTC portion of the BHP payment, we will calculate the

value of the adjusted reference premium as described below in Equations (2a) and (2b). We are finalizing these equations as proposed. Consistent with the existing approach, we will allow States to choose between using the actual current year premiums or the prior year's premiums multiplied by the PTF (described in section III.E. of this final rule). Below we describe how we will calculate the adjusted reference premium under each option.

In the case of a State that elects to use the reference premium (RP) based on the current program year (for example, 2023 premiums for the 2023 program year), Equation (2a) will be used to calculate the value of the adjusted reference premium. The RP, discussed in more detail in section III.D.1. of this final rule, is based on the second lowest cost silver plan premium in the applicable program year, in this case the current program year. The adjusted reference premium will be equal to the RP multiplied by the BHP population health factor (PHF) (described in section III.D.3. of this final rule), which will reflect the projected impact that enrolling BHP-eligible individuals in QHPs through an Exchange would have had on the average QHP premium, and multiplied by the PAF (described in section III.D.2. of this final rule). The PAF will account for the change in silver-level premiums due to the discontinuance of CSR payments. We will also multiply this value by the section 1332 waiver factor (WF) (described in section III.D.7 of this final rule), as applicable. Equation (2a) is finalized as follows:

$$\textbf{Equation (2a)}: \quad \boldsymbol{ARP_{a,g,c} = RP_{a,g,c} \times PHF \times PAF \times WFg}$$

$ARP_{a,g,c}$ = Adjusted reference premium

a = Age range

g = Geographic area

c = Coverage status (self-only or applicable category of family coverage) obtained through BHP

$RP_{a,g,c}$ = Reference premium

PHF = Population health factor

PAF = Premium adjustment factor

WF_g = Section 1332 waiver factor

In the case of a State that elected to use the RP based on the prior program year (for example, 2022 premiums for the 2023 program year), Equation (2b) will be used calculate the value of the adjusted reference premium. The adjusted reference premium will be equal to the RP for the prior program year multiplied by the BHP PHF (described in section III.D.3. of this final rule), which will reflect the projected impact that enrolling BHP-eligible individuals in QHPs on an Exchange would have had on the average QHP premium. It will then be multiplied by the PAF (described in section III.D.2. of this final methodology), which will account for the change in silver-level premiums due to the discontinuance of CSR payments. Then, it will be multiplied by the PTF (described in section III.E. of this final rule), which would reflect the projected change in the premium level between 2022 and 2023. Finally, it will be multiplied by the WF (described in section III.D.7 of this final rule). Equation (2b) is finalized as follows:

$$\textbf{Equation (2b)}: \quad \boldsymbol{ARP_{a,g,c} = RP_{a,g,c} \times PHF \times PAF \times PTF \times WFg}$$

$ARP_{a,g,c}$ = Adjusted reference premium

a = Age range

g = Geographic area

c = Coverage status (self-only or applicable category of family coverage) obtained through BHP

$RP_{a,g,c}$ = Reference premium

PHF = Population health factor

PAF = Premium adjustment factor

PTF = Premium trend factor

WF_g = Section 1332 waiver factor

Equation 3: Determination of Total Monthly Payment for BHP Enrollees in Each Rate Cell

In general, the payment rate for each rate cell will be multiplied by the number of BHP enrollees in that cell (that is, the number of enrollees that meet the criteria for each rate cell) to calculate the total monthly BHP payment. This calculation is shown in Equation (3), which we

are finalizing as proposed.

$$\boldsymbol{Equation\ (3)}: \boldsymbol{PMT} = \sum \left[\left(\boldsymbol{PTC_{a,g,c,h,i}} + \boldsymbol{CSR_{a,g,c,h,i}} \right) \times \boldsymbol{E_{a,g,c,h,i}} \right]$$

PMT = Total monthly BHP payment

$PTC_{a,g,c,h,i}$ = Premium tax credit portion of BHP payment rate

$CSR_{a,g,c,h,i}$ = Cost sharing reduction portion of BHP payment rate

$E_{a,g,c,h,i}$ = Number of BHP enrollees

a = Age range

g = Geographic area

c = Coverage status (self-only or applicable category of family coverage) obtained through BHP

h = Household size

i = Income range (as percentage of FPL)

In this equation, we will assign a value of zero to the CSR part of the BHP payment rate calculation ($\boldsymbol{CSR_{a,g,c,h,i}}$) because there is presently no available appropriation from which we can make the CSR portion of any BHP payment. In the event that an appropriation for CSRs for 2022 is made, we will determine whether and how to modify the CSR part of the BHP payment rate calculation ($\boldsymbol{CSR_{a,g,c,h,i}}$) or the PAF in the payment methodology.

B. Calculating Federal BHP Payment Rates for Each Rate Cells

We proposed to require the use of certain rate cells in applying Equations (1), (2a), (2b), and (3) of the payment methodology. Discussed in more detail below, we proposed to separate the BHP population into separate rate cells based on five factors (age, geographic area, coverage status, household size, and household income). We are finalizing use of the proposed rate cells and factors, as proposed.

Consistent with the previous payment methodologies, we also proposed that a State implementing a BHP will provide us an estimate of the number of BHP enrollees it projects will enroll in the upcoming BHP program quarter, by applicable rate cell, prior to the first quarter and each subsequent quarter of program operations until actual enrollment data is available. Upon

our approval of such estimates as reasonable, we proposed to use those estimates to calculate the prospective payment, for deposit in the State's BHP trust fund, for the first and subsequent quarters of program operation until the State provides us with actual enrollment data for those periods. The actual enrollment data is required to calculate the final BHP payment amount and make any necessary reconciliation adjustments to the prior quarters' prospective payment amounts due to differences between projected and actual enrollment. Subsequent quarterly deposits to the State's BHP trust fund will be based on the most recent actual enrollment data submitted to us. Actual enrollment data must be based on individuals enrolled for the quarter whom the State found eligible and whose eligibility was verified using eligibility and verification requirements elected by the State in its applicable BHP Blueprint for the quarter that enrollment data is submitted. These procedures, which are finalized as proposed, will ensure that Federal payments to a State reflect actual BHP enrollment during a year, within each applicable rate cell, and prospectively determine Federal payment rates for each category of BHP enrollment.

We proposed to use rate cells that separate the BHP population in each State operating a BHP into separate cells based on the five factors described below. We are finalizing all five factors as proposed.

Factor 1--Age: We will separate enrollees into rate cells by age (if applicable), using the following age ranges that capture the widest variations in premiums under HHS's Default Age Curve:[5]

- Ages 0-20.

[5] This curve is used to implement the ACA's 3:1 limit on age-rating in states that do not create an alternative rate structure to comply with that limit. The curve applies to all individual market plans, both within and outside the Exchange. The age bands capture the principal allowed age-based variations in premiums as permitted by this curve. The default age curve was updated for plan or policy years beginning on or after January 1, 2018 to include different age rating factors between children 0-14 and for persons at each age between 15 and 20. More information is available at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Downloads/StateSpecAgeCrv053117.pdf. Both children and adults under age 21 are charged the same premium. For adults age 21-64, the age bands in this rule divide the total age-based premium variation into the three most equally-sized ranges (defining size by the ratio between the highest and lowest premiums within the band) that are consistent with the age-bands used for risk-adjustment purposes in the HHS-Developed Risk Adjustment Model. For such age bands, see HHS-Developed Risk Adjustment Model Algorithm "Do It Yourself (DIY)" Software Instructions for the 2018 Benefit Year, April 4, 2019 Update, https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Updated-CY2018-DIY-instructions.pdf.

- Ages 21-34.
- Ages 35-44.
- Ages 45-54.
- Ages 55-64.

This provision is unchanged from the current methodology.[6]

Factor 2--Geographic area: For each State, we will separate enrollees into rate cells by geographic areas within which a single RP is charged by QHPs offered through the State's Exchange. Multiple, non-contiguous geographic areas will be incorporated within a single cell, so long as those areas share a common RP.[7] This provision is also unchanged from the current methodology.

Factor 3--Coverage status: We will separate enrollees into rate cells by coverage status, reflecting whether an individual is enrolled in self-only coverage or persons are enrolled in family coverage through the BHP, as provided in section 1331(d)(3)(A)(ii) of the ACA. For individuals enrolled in family coverage through the BHP, separate rate cells, as explained below, will apply based on whether such coverage involves two adults alone or whether it involves children. This provision is unchanged from the current methodology.

Factor 4--Household size: We will continue the current methods for separating enrollees into rate cells by household size that States use to determine BHP enrollees' household income as a percentage of the FPL under § 600.320 (Determination of eligibility for and enrollment in a standard health plan). We will require separate rate cells for several specific household sizes. For each additional member above the largest specified size, we will publish instructions for how we would develop additional rate cells and calculate an appropriate payment rate based on data

[6] In this document, references to the "current methodology" refer to the 2022 program year methodology as outlined in the 2022 final BHP Payment Notice.

[7] For example, a cell within a particular state might refer to "County Group 1," "County Group 2," etc., and a table for the State would list all the counties included in each such group. These geographic areas are consistent with the geographic areas established under the 2014 Market Reform Rules. They also reflect the service area requirements applicable to QHPs, as described in 45 CFR 155.1055, except that service areas smaller than counties are addressed as explained in this rule.

for the rate cell with the closest specified household size. We will publish separate rate cells for household sizes of 1 through 10. This finalized provision is unchanged from the current methodology.

Factor 5--Household Income: For households of each applicable size, we will continue the current methods for creating separate rate cells by income range, as a percentage of FPL. The PTC that a person would receive if enrolled in a QHP through an Exchange varies by household income as a percentage of the FPL as well as by the metal tier level of the QHP plans in the Exchange. Thus, separate rate cells will be used to calculate Federal BHP payment rates to reflect different bands of income measured as a percentage of FPL. We will use the following income ranges, measured as a percentage of the FPL:

- 0 to 50 percent of the FPL.
- 51 to 100 percent of the FPL.
- 101 to 138 percent of the FPL.[8]
- 139 to 150 percent of the FPL.
- 151 to 175 percent of the FPL.
- 176 to 200 percent of the FPL.

This provision is unchanged from the current methodology.

These rate cells will only be used to calculate the Federal BHP payment amount. A State implementing a BHP will not be required to use these rate cells or any of the factors in these rate cells as part of the State payment to the standard health plans participating in the BHP or to help define BHP enrollees' covered benefits, premium costs, or out-of-pocket cost-sharing levels.

Consistent with the current methodology, we are finalizing our proposal to use averages to define Federal payment rates, both for income ranges and age ranges (if applicable), rather than varying such rates to correspond to each individual BHP enrollee's age (if applicable) and

[8] The three lowest income ranges will be limited to lawfully present immigrants who are ineligible for Medicaid because of immigration status.

income level. This approach will increase the administrative feasibility of making Federal BHP payments and reduce the likelihood of error resulting from highly complex methodologies. This approach should not significantly change Federal payment amounts, since within applicable ranges the BHP-eligible population is distributed relatively evenly.

The number of factors contributing to rate cells, when combined, can result in over 350,000 rate cells, which can increase the complexity when generating quarterly payment amounts. In future years, and in the interest of administrative simplification, we will consider whether to combine or eliminate certain rate cells, once we are certain that the effect on payment would be insignificant.

C. Sources and State Data Considerations

To the extent possible, unless otherwise provided, we will continue to use data submitted to the Federal government by QHP issuers seeking to offer coverage through the Exchange in the relevant BHP State to perform the calculations that determine Federal BHP payment cell rates.

States operating an SBE in the individual market must provide data to support the development of the Federal BHP payment rates in those States, for example premiums for their second lowest cost silver plans, by geographic area. We proposed that States operating BHPs interested in obtaining the applicable 2023 program year Federal BHP payment rates for its State must submit the needed data accurately, completely, and as specified by CMS, by no later than October 15, 2022. Because we are finalizing this rule after October 15, 2022, States must submit this data to CMS within 30 days of publication of this final rule. If additional State data (that is, in addition to the second lowest cost silver plan premium data) are needed to determine the Federal BHP payment rate, such data must be submitted in a timely manner, and in a format specified by us to support the development and timely release of annual BHP Payment Methodologies. The specifications for data collection to support the development of BHP payment rates are published in CMS guidance and are available on the Basic Health Program page of Medicaid.gov, https://www.medicaid.gov/sites/default/files/2019-11/premium-data-

collection-tool.zip.

States operating a BHP should be technologically prepared to begin submitting actual enrollment data at the start of their BHP, starting with the beginning of the first program year. States must submit actual enrollment data to CMS on a quarterly basis thereafter. This differs from the enrollment estimates used to calculate the initial BHP payment, which States would generally submit to CMS 60 days before the start of the first quarter of the program start date. This requirement is necessary for us to implement the payment methodology that is tied to a quarterly reconciliation based on actual enrollment data.

We are finalizing our proposal to continue the policy first adopted in the 2016 final BHP payment methodology that in States that have BHP enrollees who do not file Federal tax returns (non-filers), the State must develop a methodology to determine the enrollees' household income and household size consistently with Exchange requirements.[9] The State must submit this methodology, which is subject to CMS approval, to us at the time of their Blueprint submission. We reserve the right to approve or disapprove the State's methodology to determine household income and household size for non-filers if the household composition and/or household income resulting from application of the methodology are different from what typically would be expected to result if the individual or head of household in the family were to file a tax return. States currently operating a BHP that wish to change the methodology for non-filers must submit a revised Blueprint outlining the revisions to its methodology, consistent with § 600.125.

In addition, as the Federal payments are determined quarterly and the enrollment data is required to be submitted by the States to us quarterly, the quarterly payment will be based on the characteristics of the enrollee at the beginning of the quarter (or their first month of enrollment in the BHP in each quarter). Thus, if an enrollee were to experience a change in county of residence, household income, household size, or other factors related to the BHP payment

[9] See "Basic Health Program; Federal Funding Methodology for Program Years 2017 and 2018," 81 FR 10091 at 10097, February 29, 2016.

determination during the quarter, the payment for the quarter will be based on the data as of the beginning of the quarter (or their first month of enrollment in the BHP in the applicable quarter). Payments will still be made only for months that the person is enrolled in and eligible for the BHP. We do not anticipate that this will have a significant effect on the Federal BHP payment. The States must maintain data that is consistent with CMS' verification requirements, including auditable records for each individual enrolled, indicating an eligibility determination and a determination of income and other criteria relevant to the payment methodology as of the beginning of each quarter.

Consistent with § 600.610 (Secretarial determination of BHP payment amount), the State is required to submit certain data in accordance with this final rule. We require that this data be collected and validated by States operating a BHP, and that this data be submitted to CMS.

D. Discussion of Specific Variables Used in Payment Equations

1. Reference Premium (RP)

As explained in section III.D.5. of this final rule, the PTC is based, in part, on the premiums for the applicable second lowest cost silver plan offered through the Exchange operating in the state. To calculate the estimated PTC that would be paid if BHP-eligible individuals enrolled in QHPs through an Exchange, we must calculate a RP. For the purposes of calculating the BHP payment rates, the RP, in accordance with 26 U.S.C. 36B(b)(3)(C), is defined as the adjusted monthly premium for an applicable second lowest cost silver plan. The applicable second lowest cost silver plan is defined in 26 U.S.C. 36B(b)(3)(B) as the second lowest cost silver plan of the individual market in the rating area in which the taxpayer resides that is offered through the same Exchange. We will use the adjusted monthly premium for an applicable second lowest cost silver plan in the applicable program year (2023) as the RP (except in the case of a State that elects to use the prior plan year's premium as the basis for the Federal BHP payment for 2022, as described in section III.E. of this final rule). This method is unchanged from the current methodology except to update the reference years, and to provide

additional methodological details to simplify calculations and to deal with potential ambiguities.

The RP used for purposes of calculating the Federal BHP payment will be the premium applicable to non-tobacco users. This is consistent with the provision in 26 U.S.C. 36B(b)(3)(C) that bases the PTC on premiums that are adjusted for age alone, without regard to tobacco use, even for States that allow insurers to vary premiums based on tobacco use in accordance with 42 U.S.C. 300gg(a)(1)(A)(iv).

Consistent with the policy set forth in 26 CFR 1.36B-3(f)(6), to calculate the PTC for those enrolled in a QHP through an Exchange, we will not update the payment methodology, and subsequently the Federal BHP payment rates, in the event that the second lowest cost silver plan used as the RP, or the lowest cost silver plan, changes (that is, terminates or closes enrollment during the year).

The applicable second lowest cost silver plan premium will be included in the BHP payment methodology by age range (if applicable), geographic area, and self-only or applicable category of family coverage obtained through the BHP.

We note that the choice of the second lowest cost silver plan for calculating BHP payments relies on several simplifying assumptions in its selection. For the purposes of determining the second lowest cost silver plan for calculating PTC for a person enrolled in a QHP through an Exchange, the applicable plan may differ for various reasons. For example, the second lowest cost silver plan for a family consisting of two adults, their child, and their niece may be different than the second lowest cost silver plan for a family with two adults and their children, because one or more QHPs in the family's geographic area might not offer family coverage that includes a niece. We believe that it would not be possible to replicate such variations for calculating the BHP payment and believe that in the aggregate, they will not result in a significant difference in the payment. Thus, we will use the second lowest cost silver plan available to any enrollee for a given age, geographic area, and coverage category.

This choice of RP relies on an assumption about enrollment in the Exchanges. In the

payment methodologies for program years 2015 through 2019, we had assumed that all persons enrolled in the BHP would have elected to enroll in a silver level plan if they had instead enrolled in a QHP through an Exchange (and that the QHP premium would not be lower than the value of the PTC). In the November 2019 final BHP Payment Notice, we continued to use the second-lowest cost silver plan premium as the RP, but for the 2020 payments we changed the assumption about which metal tier plans enrollees would choose, by adding the Metal Tier Selection Factor (MTSF). In the final 2022 payment methodology, we removed the MTSF. We will continue the approach taken in the final 2022 payment methodology and not apply the MTSF in this 2023 payment methodology.

We do not believe it is appropriate to adjust the payment for an assumption that some BHP enrollees would not have enrolled in QHPs for purposes of calculating the BHP payment rates, since section 1331(d)(3)(A)(ii) of the ACA requires the calculation of such rates as if the enrollee had enrolled in a QHP through an Exchange.

The applicable age bracket (if any) will be one dimension of each rate cell. We proposed to assume a uniform distribution of ages and estimate the average premium amount within each rate cell. We believe that assuming a uniform distribution of ages within these ranges is a reasonable approach and would produce a reliable determination of the total monthly payment for BHP enrollees. We also believe this approach will avoid potential inaccuracies that could otherwise occur in relatively small payment cells if age distribution were measured by the number of persons eligible or enrolled. We have used this approach starting since the 2015 program year. We believe that other approaches (that is, other than assuming uniform age distribution) could skew the calculation of the payment rates for each rate cell. Given the number of rate cells and the fact that in some cases the number of enrollees in a cell may be small (particularly for less common family sizes, smaller counties, etc.), we believe that using estimates of age distribution or historical data also could skew results. We also believe a uniform age distribution is reasonably simple to use and avoids increasing burden on States to report data

to CMS. We have found this approach reliable to date.

We will use geographic areas based on the rating areas used in the Exchanges. We will define each geographic area so that the RP is the same throughout the geographic area. When the RP varies within a rating area, we will define geographic areas as aggregations of counties with the same RP. Although plans are allowed to serve geographic areas smaller than counties after obtaining our approval, no geographic area, for purposes of defining BHP payment rate cells, will be smaller than a county. We believe that the benefits of simplifying both the calculation of BHP payment rates and the operation of the BHP justify any impacts on Federal payment levels.

Finally, in terms of the coverage category, Federal payment rates will only recognize self-only and two-adult coverage, with exceptions that account for children who are potentially eligible for the BHP. First, in States that set the upper income threshold for children's Medicaid and CHIP eligibility below 200 percent of FPL (based on modified adjusted gross income (MAGI)), children in households with incomes between that threshold and 200 percent of FPL would be potentially eligible for the BHP. Currently, the only States in this category are Idaho and North Dakota.[10] Second, the BHP will include lawfully present immigrant children with household incomes at or below 200 percent of FPL in States that have not exercised the option under sections 1903(v)(4)(A)(ii) and 2107(e)(1)(E) of the Act to qualify all otherwise eligible, lawfully present immigrant children for Medicaid and CHIP. States that fall within these exceptions will be identified based on their Medicaid and CHIP State Plans, and the rate cells will include appropriate categories of BHP family coverage for children. For example, Idaho's Medicaid and CHIP eligibility is limited to families with MAGI at or below 185 percent FPL. If Idaho implemented a BHP, Idaho children with household incomes between 185 and 200 percent could qualify. In other States, BHP eligibility will generally be restricted to adults, since

[10] Center for Medicaid and CHIP Services (CMCS). "State Medicaid, CHIP and BHP Income Eligibility Standards Effective October 1, 2020."

children who are citizens or lawfully present immigrants and live in households with incomes at or below 200 percent of FPL will qualify for Medicaid or CHIP, and thus be ineligible for a BHP under section 1331(e)(1)(C) of the ACA, which limits a BHP to individuals who are ineligible for minimum essential coverage (as defined in 26 U.S.C. 5000A(f)).

2. Premium Adjustment Factor (PAF)

The PAF considers the premium increases in other States that took effect after we discontinued payments to issuers for CSRs provided to enrollees in QHPs offered through Exchanges. Despite the discontinuance of Federal payments for CSRs, QHP issuers are required to provide CSRs to eligible enrollees. As a result, many QHP issuers increased the silver-level plan premiums to account for those additional costs; adjustments and how those were applied (for example, to only silver-level plans or to all metal tier plans) varied across States. For the States operating BHPs in 2018, the increases in premiums were relatively minor, because the majority of enrollees eligible for CSRs (and all who were eligible for the largest CSRs) were enrolled in the BHP and not in QHPs on the Exchanges, and therefore issuers in BHP States did not significantly raise premiums to cover costs related to HHS not making CSR payments.

In the Final Administrative Order and the 2019 through 2022 final BHP Payment Notices, we incorporated the PAF into the BHP payment methodologies to capture the impact of how other States responded to us ceasing to make CSR payments. We will include the PAF in the 2023 payment methodology and will calculate it in the same manner as in the Final Administrative Order. In the event that an appropriation for CSRs for 2023 is made, we would determine whether and how to modify the PAF in the payment methodology.

Under the Final Administrative Order,[11] we calculated the PAF by using information sought from QHP issuers in each State and the District of Columbia, and we determined the premium adjustment that the responding QHP issuers made to each silver level plan in 2018 to account for the discontinuation of CSR payments to QHP issuers. Based on the data collected,

[11] https://www.medicaid.gov/sites/default/files/2019-11/final-admin-order-2018-revised-payment-methodology.pdf

we estimated the median adjustment for silver level QHPs nationwide (excluding those in the two BHP States). To the extent that QHP issuers made no adjustment (or the adjustment was zero), this would be counted as zero in determining the median adjustment made to all silver level QHPs nationwide. If the amount of the adjustment was unknown—or we determined that it should be excluded for methodological reasons (for example, the adjustment was negative, an outlier, or unreasonable)—then we did not count the adjustment towards determining the median adjustment.[12] The median adjustment for silver level QHPs is the nationwide median adjustment.

For each of the two BHP States, we determined the median premium adjustment for all silver level QHPs in that State, which we refer to as the State median adjustment. The PAF for each BHP State equaled one plus the nationwide median adjustment divided by one plus the State median adjustment for the BHP State. In other words:

PAF = (1 + Nationwide Median Adjustment) ÷ (1 + State Median Adjustment).

To determine the PAF described above, we sought to collect QHP information from QHP issuers in each State and the District of Columbia to determine the premium adjustment those issuers made to each silver level plan offered through the Exchange in 2018 to account for the end of CSR payments. Specifically, we sought information showing the percentage change that QHP issuers made to the premium for each of their silver level plans to cover benefit expenditures associated with the CSRs, given the lack of CSR payments in 2018. This percentage change was a portion of the overall premium increase from 2017 to 2018.

According to our records, there were 1,233 silver level QHPs operating on Exchanges in 2018. Of these 1,233 QHPs, 318 QHPs (25.8 percent) responded to our request for the percentage adjustment applied to silver level QHP premiums in 2018 to account for the discontinuance of the CSRs. These 318 QHPs operated in 26 different States, with 10 of those

[12] Some examples of outliers or unreasonable adjustments include (but are not limited to) values over 100 percent (implying the premiums doubled or more because of the adjustment), values more than double the otherwise highest adjustment, or non-numerical entries.

States running SBEs (while we requested information only from QHP issuers in States serviced by an FFE, many of those issuers also had QHPs in States operating SBEs and submitted information for those States as well). Thirteen of these 318 QHPs were in New York (and none were in Minnesota). Excluding these 13 QHPs from the analysis, the nationwide median adjustment was 20.0 percent. Of the 13 QHPs in New York that responded, the State median adjustment was 1.0 percent. We believe that this is an appropriate adjustment for QHPs in Minnesota, as well, based on the observed changes in New York's QHP premiums in response to the discontinuance of CSR payments (and the operation of the BHP in that State) and our analysis of expected QHP premium adjustments for States with BHPs. We calculated the final PAF as (1 + 20%) ÷ (1 + 1%) (or 1.20/1.01), which results in a value of 1.188.

We are finalizing our proposal to continue to set the PAF to 1.188 for program year 2023, with one limited exception as described below. We believe that this value for the PAF continues to reasonably account for the increase in silver-level premiums experienced in non-BHP States that took effect after the discontinuance of the CSR payments. We believe that the impact of the increase in silver-level premiums in 2022 can reasonably be expected to be similar to that in 2018, because the discontinuation of CSR payments has not changed. Moreover, we believe that States and QHP issuers have not significantly changed the manner and degree to which they are increasing QHP silver-level premiums to account for the discontinuation of CSR payments since 2018, and we expect the same for 2023.

In addition, the percentage difference between the average second lowest cost silver level QHP and the bronze-level QHP premiums has not changed significantly since 2018, and we do not expect a significant change for 2023. In 2018, the average second lowest cost silver level QHP premium was 41.1 percent higher than the average lowest cost bronze level QHP premium ($481 and $341, respectively). In 2022, (the latest year for which premiums have been published), the difference was modestly lower; the average second lowest cost silver level QHP premium was 33.1 percent higher than the average lowest cost bronze level QHP premium ($438

and $329, respectively).[13] In contrast, the average second lowest cost silver level QHP premium was only 23.8 percent higher than the average lowest cost bronze level QHP premium in 2017 ($359 and $290, respectively).[14] If there were a significant difference in the amounts that QHP issuers were increasing premiums for silver level QHPs to account for the discontinuation of CSR payments over time, then we would expect the difference between the bronze level and silver level QHP premiums to change significantly over time, and that this would be apparent in comparing the lowest-cost bronze-level QHP premium to the second lowest cost silver level QHP premium.

We are finalizing our proposal to make one limited exception in setting the value of the PAF, for States in the first year of implementing a BHP. In the case of a State in the first year of implementing a BHP, if the State chooses to use prior year second lowest cost silver level QHP premium to determine the BHP payment (for example, the 2022 premiums for the 2023 program year), we will set the value of the PAF to 1.00. In this case, we believe that adjustment to the QHP premiums to account for the discontinuation of CSR payments would be included fully in the prior year premiums. If the State chooses to use the prior year premiums, then no further adjustment would be necessary for the BHP payments; therefore, the value of the PAF will be 1.00.

3. Population Health Factor (PHF)

We are finalizing our proposal to include the PHF in the methodology to account for the potential differences in the average health status between BHP enrollees and persons enrolled through the Exchanges. To the extent that BHP enrollees would have been enrolled through an Exchange in the absence of a BHP in a State, the exclusion of those BHP enrollees in the Exchange may affect the average health status of the overall population and the expected QHP

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[13] Kaiser Family Foundation, "Average Marketplace Premiums by Metal Tier, 2018-2022," https://www.kff.org/health-reform/state-indicator/average-marketplace-premiums-by-metal-tier/. [Accessed August 1, 2022.]

[14] See Basic Health Program: Federal Funding Methodology for Program Years 2019 and 2020; Final Methodology, 84 FR 59529 at 59532 (November 5, 2019).

premiums.

We currently do not believe that there is evidence that the BHP population would have better or poorer health status than the Exchange population. At this time, there continues to be a lack of data on the experience in the Exchanges that limits the ability to analyze the potential health differences between these groups of enrollees. More specifically, Exchanges have been in operation since 2014, and 2 States have operated BHPs since 2015, but data is not available to do the analysis necessary to determine if there are differences in the average health status between BHP and Exchange enrollees. In addition, differences in population health may vary across States. We also do not believe that sufficient data would be available to permit us to make a prospective adjustment to the PHF under § 600.610(c)(2) for the 2023 program year.

Given these analytic challenges and the limited data about Exchange coverage and the characteristics of BHP-eligible consumers, the PHF will be 1.00 for program year 2023.

In previous years' BHP payment methodologies, we included an option for States to include a retrospective population health status adjustment. States will have same option for 2023 to include a retrospective population health status adjustment in the certified methodology, which is subject to our review and approval. This option is described further in section III.F. of this final rule. Regardless of whether a State elects to include a retrospective population health status adjustment, we anticipate that, in future years, when additional data becomes available about Exchange coverage and the characteristics of BHP enrollees, we may propose a different PHF.

While the statute requires consideration of risk adjustment payments and reinsurance payments insofar as they would have affected the PTC that would have been provided to BHP-eligible individuals had they enrolled in QHPs, we are not requiring that a BHP's standard health plans receive such payments. As explained in the BHP final rule, BHP standard health plans are not included in the Federally-operated risk adjustment program.[15] Further, standard health plans

[15] See 79 FR 14131.

did not qualify for payments under the transitional reinsurance program established under section 1341 of the ACA for the years the program was operational (2014 through 2016).[16] To the extent that a State operating a BHP determines that, because of the distinctive risk profile of BHP-eligible consumers, BHP standard health plans should be included in mechanisms that share risk with other plans in the State's individual market, the State would need to use other methods for achieving this goal.

4. Household Income (I)

Household income is a significant determinant of the amount of the PTC that is provided for persons enrolled in a QHP through an Exchange. Accordingly, all BHP Payment Methodologies incorporate household income into the calculations of the payment rates through the use of income-based rate cells. We are finalizing our proposal to define household income in accordance with the definition of modified adjusted gross income in 26 U.S.C. 36B(d)(2)(B) and consistent with the definition in 45 CFR 155.300. Income will be measured relative to the FPL, which is updated periodically in the **Federal Register** by the Secretary under the authority of 42 U.S.C. 9902(2). Household size and income as a percentage of FPL will be used as factors in developing the rate cells. We are finalizing our proposal to use the following income ranges measured as a percentage of FPL:[17]

- 0–50 percent.
- 51–100 percent.
- 101–138 percent.
- 139–150 percent.
- 151-175 percent.
- 176-200 percent.

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[16] See 45 CFR 153.400(a)(2)(iv) (BHP standard health plans are not required to submit reinsurance contributions), 153.20 (definition of "Reinsurance-eligible plan" as not including "health insurance coverage not required to submit reinsurance contributions"), 153.230(a) (reinsurance payments under the national reinsurance parameters are available only for "Reinsurance-eligible plans").

[17] These income ranges and this analysis of income apply to the calculation of the PTC.

We are finalizing our proposal to assume a uniform income distribution for each Federal BHP payment cell. We believe that assuming a uniform income distribution for the income ranges finalized will be reasonably accurate for the purposes of calculating the BHP payment and would avoid potential errors that could result if other sources of data were used to estimate the specific income distribution of persons who are eligible for or enrolled in the BHP within rate cells that may be relatively small.

Thus, when calculating the mean, or average, PTC for a rate cell, we will calculate the value of the PTC at each one percentage point interval of the income range for each Federal BHP payment cell and then calculate the average of the PTC across all intervals. This calculation would rely on the PTC formula described in section III.D.5. of this final rule.

As the APTC for persons enrolled in QHPs would be calculated based on their household income during the open enrollment period, and that income would be measured against the FPL at that time, we will adjust the FPL by multiplying the FPL by a projected increase in the CPI-U between the time that the BHP payment rates are calculated and the QHP open enrollment period, if the FPL is expected to be updated during that time. The projected increase in the CPI-U will be based on the intermediate inflation forecasts from the most recent Old-Age, Survivors, and Disability Insurance (OASDI) and Medicare Trustees Reports. [18]

5. Premium Tax Credit Formula (PTCF)

In Equation 1, described in section III.A.1. of this final rule, we are finalizing our proposal to use the formula described in 26 U.S.C. 36B(b) to calculate the estimated PTC that would be paid on behalf of a person enrolled in a QHP on an Exchange as part of the BHP payment methodology. This formula is used to determine the contribution amount (the amount of premium that an individual or household theoretically would be required to pay for coverage in a QHP on an Exchange), which is based on (A) the household income; (B) the household

[18] *See* Table IV A1 from the 2020 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, available at https://www.cms.gov/files/document/2020-medicare-trustees-report.pdf.

income as a percentage of FPL for the family size; and (C) the schedule specified in 26 U.S.C. 36B(b)(3)(A) and shown below.

The difference between the contribution amount and the adjusted monthly premium (that is, the monthly premium adjusted for the age of the enrollee) for the applicable second lowest cost silver plan is the estimated amount of the PTC that would be provided for the enrollee.

The PTC amount provided for a person enrolled in a QHP through an Exchange is calculated in accordance with the methodology described in 26 U.S.C. 36B(b)(2). The amount is equal to the lesser of the premium for the plan in which the person or household enrolls, or the adjusted premium for the applicable second lowest cost silver plan minus the contribution amount.

The applicable percentage is defined in 26 U.S.C. 36B(b)(3)(A) and 26 CFR 1.36B-3(g) as the percentage that applies that applies to a taxpayer's household income that is within an income tier, increasing on a sliding scale in a linear manner from an initial premium percentage to a final premium percentage. We are finalizing our proposal to continue to use applicable percentages to calculate the estimated PTC that would be paid on behalf of a person enrolled in a QHP on an Exchange as part of the BHP payment methodology as part of Equation 1.

As described in section II.D.5 of the 2023 BHP proposed rule, we are finalizing our proposal to use the formula described in 26 U.S.C. 36B(b) to calculate the estimated PTC that would be paid on behalf of a person enrolled in a QHP in the Marketplace as part of the BHP payment methodology. In 2021 and 2022, the applicable percentages defined in 26 U.S.C. 36B(b)(3)(A) and 26 CFR 1.36B-3(g) were set in the American Rescue Plan Act of 2021 (Pub. L. 117-2, enacted March 11, 2021). We used those applicable percentages for program years 2021 and 2022. Section 12001 of Subtitle C of the Inflation Reduction Act of 2022 (Pub. L. 117-169, enacted August 16, 2022) extended these applicable percentages for the years 2023 through 2025. Therefore, we will use the applicable percentages in Table 1 for the 2023 BHP program year.

The updated applicable percentages, which are described in Table 1, increase on a sliding scale in a linear manner from the premium percentage applicable to individuals with income at the lowest end of the premium band to the premium percentage applicable to individuals with income at the highest end of the premium band.

TABLE 1: Applicable Percentage Table for CY 2023
Under Section 12001 of the Inflation Reduction Act of 2022

In the case of household income (expressed as a percent of poverty line) within the following income tier:	The initial premium percentage is–	The final premium percentage is–
Up to 150%	0.0%	0.0%
150.0% percent up to 200.0%	0.0%	2.0%
200.0% up to 250.0%	2.0%	4.0%
250.0% up to 300.0%	4.0%	6.0%
300.0 percent up to 400.0%	6.0%	8.5%
400.0% percent and higher	8.5%	8.5%

6. Income Reconciliation Factor (IRF)

For persons who enroll, or enroll a family member, in a QHP through an Exchange for which APTC is paid, a reconciliation is required by 26 U.S.C. 36B(f) following the end of the coverage year. The reconciliation requires the enrolling individual (the taxpayer) to compare the total amount of APTC paid on behalf of the taxpayer or a family member of the taxpayer for the year of coverage to the total amount of PTC allowed for the year of coverage, based on household circumstances shown on the Federal income tax return. If the amount of a taxpayer's PTC exceeds the APTC paid on behalf of the taxpayer, the difference reduces the taxpayer's tax liability for the year of coverage or results in a refund to the extent it exceeds the taxpayer's tax liability. If the APTC exceeds the PTC allowed, the taxpayer must increase his or her tax liability for the year of coverage by the difference, subject to certain limitations in statute and regulation.

Section 1331(e)(2) of the ACA specifies that an individual eligible for the BHP may not be treated as a "qualified individual" under section 1312 of the ACA who is eligible for enrollment in a QHP offered through an Exchange. We are defining "eligible for the BHP" to mean anyone for whom the State agency or the Exchange assesses or determines, based on the single streamlined application or renewal form, as eligible for enrollment in the BHP. Because

enrollment in a QHP is a requirement for individuals to receive APTC, individuals determined or assessed as eligible for a BHP are not eligible to receive APTC for coverage in the Exchange. Because they do not receive APTC, BHP enrollees are not subject to the same income reconciliation as Exchange enrollees.

Nonetheless, there may still be differences between a BHP enrollee's household income reported at the beginning of the year and the actual household income over the year. These may include small changes (reflecting changes in hourly wage rates, hours worked per week, and other fluctuations in income during the year) and large changes (reflecting significant changes in employment status, hourly wage rates, or substantial fluctuations in income). There may also be changes in household composition. Thus, we believe that using unadjusted income as reported prior to the BHP program year may result in calculations of estimated PTC that are inconsistent with the actual household incomes of BHP enrollees during the year. Even if the BHP adjusts household income determinations and corresponding claims of Federal payment amounts based on household reports during the year or data from third-party sources, such adjustments may not fully capture the effects of tax reconciliation that BHP enrollees would have experienced had they been enrolled in a QHP through an Exchange with APTC.

Therefore, in accordance with current practice, we are finalizing our proposal to include in Equation 1 an adjustment, the IRF, that will account for the difference between calculating estimated PTC using: (a) household income relative to FPL as determined at initial application and potentially revised mid-year under § 600.320, for purposes of determining BHP eligibility and claiming Federal BHP payments; and (b) actual household income relative to FPL received during the plan year, as it would be reflected on individual Federal income tax returns. This adjustment will seek prospectively to capture the average effect of income reconciliation aggregated across the BHP population had those BHP enrollees been subject to tax reconciliation after receiving APTC for coverage provided through QHPs. Consistent with the methodology used in past years, we will estimate reconciliation effects based on tax data for 2 years, reflecting

income and tax unit composition changes over time among BHP-eligible individuals.

The OTA maintains a model that combines detailed tax and other data, including Exchange enrollment and PTC claimed, to project Exchange premiums, enrollment, and tax credits. For each enrollee, this model compares the APTC based on household income and family size estimated at the point of enrollment with the PTC based on household income and family size reported at the end of the tax year. The former reflects the determination using enrollee information furnished by the applicant and tax data furnished by the IRS. The latter would reflect the PTC eligibility based on information on the tax return, which would have been determined if the individual had not enrolled in the BHP. Consistent with prior years, we will use the ratio of the reconciled PTC to the initial estimation of PTC as the IRF in Equation (1) for estimating the PTC portion of the BHP payment rate.

We are finalizing our proposal to distinguish between the IRF for Medicaid expansion States and non-Expansion States to remove data for those with incomes under 138 percent of FPL for Medicaid expansion States. This is the same approach that we finalized in the 2021 and 2022 final BHP Payment Notices. Therefore, we proposed to set the value of the IRF for States that have expanded Medicaid equal to the value of the IRF for incomes between 138 and 200 percent of FPL and the value of the IRF for States that have not expanded Medicaid equal to the value of the IRF for incomes between 100 and 200 percent of FPL. This gives an IRF of 100.66 percent for States that have expanded Medicaid and 101.63 percent for States that have not expanded Medicaid for program year 2023. Both current States operating a BHP have expanded Medicaid eligibility, and therefore we finalize the value of the IRF to be 100.66 percent.

We will use this value for the IRF in Equation (1) for calculating the PTC portion of the BHP payment rate.

7. Section 1332 Waiver Factor (WF)

Section 1332 of the ACA permits States to apply for a waiver from certain ACA requirements to pursue innovative strategies for providing their residents with access to high

quality, affordable health insurance coverage while retaining the basic protections of the ACA. Section 1332 of the ACA authorizes the Secretary of HHS and the Secretary of the Treasury (collectively, the Secretaries) to approve a State's request to waive all or any of the following requirements falling under their respective jurisdictions for health insurance coverage within a State for plan years beginning on or after January 1, 2017: (1) Part I of subtitle D of Title I of the ACA (relating to the establishment of QHPs); (2) Part II of subtitle D of Title I of the ACA (relating to consumer choices and insurance competition through Health Benefit Exchanges); (3) Section 1402 of the ACA (relating to reduced cost sharing for individuals enrolling in QHPs); and (4) Sections 36B (relating to refundable credits for coverage under a QHP), 4980H (relating to shared responsibility for employers regarding health coverage), and 5000A (relating to the requirement to maintain minimum essential coverage) of the Internal Revenue Code (Code).

Under section 1332 of the ACA, the Secretaries may exercise their discretion to approve a request for a section 1332 waiver only if the Secretaries determine that the proposal for the section 1332 waiver meets the following four requirements, referred to as the statutory guardrails: (1) The proposal will provide coverage that is at least as comprehensive as coverage defined in section 1302(b) of the ACA and offered through Exchanges established under title I of the ACA, as certified by the Office of the Actuary of CMS, based on sufficient data from the State and from comparable States about their experience with programs created by the ACA and the provisions of the ACA that would be waived; (2) the proposal will provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable for the State's residents as would be provided under title I of the ACA; (3) the proposal will provide coverage to at least a comparable number of the State's residents as would be provided under title I of the ACA; and (4) the proposal will not increase the Federal deficit.[19]

The Secretaries retain their discretionary authority under section 1332 of the ACA to

[19] See section 1332(b)(1)(A) through (D) of the ACA, 45 CFR 155.1308(f)(3)(iv)(A) through (D), and 31 CFR 33.108(f)(3)(iv)(A) through (D).

deny waivers when appropriate given consideration of the application as a whole, even if an application meets the four statutory guardrails. Eighteen (18) States have approved section 1332 waivers for plan year 2023.[20]

Section 1332(a)(3) of the ACA directs the Secretaries to pay pass-through funding to the State for the purpose of implementing the State's section 1332 waiver. Under an approved section 1332 waiver, a State may receive pass-through funding associated with the resulting reductions in Federal spending on Exchange financial assistance (PTC, CSRs, and small business tax credits (SBTC)) consistent with the statute and reduced as necessary to ensure deficit neutrality. These payments are made in compliance with the applicable waiver plans, the specific terms and conditions governing the waiver, and accompanying statutory and regulatory requirements. Specifically, section 1332(a)(3) of the ACA provides that pass-through funding shall be paid to States for purposes of implementing the States' waiver plans. The specific impacts of the waivers on premiums and PTCs vary across States and plan years, depending, in part, on the State's approved section 1332 waiver plan and the design of the State's program.[21] The regulations at 31 CFR 33.122 and 45 CFR 155.1322 specify that pass-through funding amounts will be calculated annually by the Departments for States with approved waivers.[22] Additionally, section 1332(a)(4)(B)(v) of the ACA requires that the Secretaries issue regulations that provide a process for periodic evaluations by the Secretaries of the program under the waiver.[23] As implemented by the Departments, the periodic evaluations include evaluation of pass-through funding and associated reporting and methodologies. Information on the pass-

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[20] See the CMS section 1332 waiver website for information on approved waivers: *https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-*

[21] For example, some State reinsurance programs under a section 1332 waiver have reduced Statewide average QHP premiums by 4 percent to 40 percent compared to what premiums would have been without the waiver. See Data Brief on Section 1332 waivers: State-based reinsurance programs available here *https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/1332-Data-Brief-Aug2021.pdf.*

[22] See section 1332(a)(3) of the ACA. See also Patient Protection and Affordable Care Act; Updating Payment Parameters and Improving Health Insurance Markets for 2022 and Beyond; Final Rule, 86 FR 53412 at 53482-53483 (Sep 27, 2021).

[23] See 31 CFR 33.128 and 45 CFR 155.1328.

through funding amounts is made available publicly on the CMS website.[24]

For a State that operates a BHP and an approved section 1332 waiver, the Federal BHP can have an impact on section 1332 waiver pass-through funding for that State. For example, the existence of a Federal BHP impacts aggregate PTC amounts in the State because BHP moves some individuals, who would otherwise be eligible for PTC, out of Exchange coverage. Similarly, as the section 1332 waiver may impact the benchmark QHP premiums and the PTCs in a State, the waiver may also have an effect on the calculation of Federal BHP payments in a State operating a BHP.

If the section 1332 waiver reduces premiums for eligible enrollees, then this can lead to a reduction in the amount of PTC available for eligible enrollees (in particular, if the second lowest-cost silver QHP premium is reduced). While this may not have an effect on particular subsidized QHP enrollees, as their share of the premium would remain unchanged, it would reduce the amount of Federal outlays for PTC. With respect to a State's approved section 1332 waiver, the amount of Federal pass-through funding would equal the difference between (1) the amount, determined annually by the Secretaries, of PTC under section 36B of the Code, the SBTC under section 45R of the Code, or CSRs under part I of subtitle E of the ACA (collectively referred to as Exchange financial assistance) that individuals and small employers in the State would otherwise be eligible for had the State not received approval for its section 1332 waiver and (2) the amount of Exchange financial assistance that individuals and small employers are eligible for with the approved section 1332 waiver in place. The section 1332 waiver pass-through amount would not be increased to account for any savings or decreases in Federal spending other than the reduction in Exchange financial assistance. This pass-through amount for the section 1332 waiver would be reduced by any net increase in Federal spending or net decrease in Federal revenue if necessary to ensure deficit neutrality. The State must use this

[24] See the CMS section 1332 website for information on pass-through funding here: *https://www.cms.gov/CCIIO/ Programs-and-Initiatives/ State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-.*

pass-through funding only for purposes of implementing the plan associated with the State's approved section 1332 waiver. Therefore, in States that operate only an approved section 1332 waiver, the net expected Federal spending is the same, even though the amount of PTC paid by the Federal government is lower.

However, for a State that operates a BHP and a section 1332 waiver, a reduction in the expected Federal PTC payments due to the operation of the waiver leads directly to a reduction in Federal BHP funding to the State under the current BHP methodology. The amount of PTC and CSRs individuals are eligible for in the Exchange is dependent on the cost of the second lowest cost silver plan premium, and the cost of the second lowest cost silver plan premium is the basis for determining the amount of Federal funding for its BHP program. Therefore, a reduction in second lowest cost silver plan premium due to a section 1332 waiver, also reduces the Federal BHP payment. These reductions may be substantial. For example, in Minnesota in 2021, the State's section 1332 waiver resulted in a State-wide average premium reduction of 21.3 percent compared to without the waiver. This led to a similar reduction in PTC paid, and thus a similar reduction in Federal BHP funding. While the PTC allowed for persons eligible for subsidized coverage in the Exchange is lower with the section 1332 waiver in place, the reduction in premiums means that the net benefit to those individuals has not decreased—rather, Federal funding has been shifted from PTC in part to pass-through payments made to the State.

On January 28, 2021, President Biden issued Executive Order (E.O.) 14009 directing HHS, and the heads of all other executive departments and agencies with authorities and responsibilities related to Medicaid and the ACA, to review all existing regulations, orders, guidance documents, policies, and any other similar agency actions to determine whether such agency actions are inconsistent with the policy set forth in section 1 of E.O. 14009 to protect and strengthen the ACA.[25] As part of this review, we considered the impact of approved section 1332 waivers on Federal BHP funding and vice versa in States that elect to operate both a BHP

[25] 86 FR 7793 (February 2, 2021).

and an approved section 1332 waiver, including the impact in Minnesota, as previously discussed.

We determined it is appropriate to account for the impact of an approved section 1332 waiver when calculating Federal BHP payments. This is necessary for consistency with E.O. 14009 and this Administration's goal of protecting and strengthening the ACA and making high-quality, affordable health care accessible for every American. We believe that it is appropriate to consider the amount of pass-through funding associated with the section 1332 waiver as part of the PTC for the purpose of determining the BHP payments. As described previously, while the PTC allowed may be reduced under the section 1332 waiver, the benefit to the persons eligible for such subsidized coverage has not decreased. Considering the section 1332 pass-through funding as part of the PTC for purposes of determining the BHP payment also counteracts the reduction in Federal BHP funding for States that lawfully exercise the flexibility Congress provided to implement both of the alternative State programs under sections 1331 and 1332 of the ACA. Therefore, we are finalizing our proposal to add the section 1332 WF for the 2023 BHP payment methodology. This factor will be calculated as the ratio of (1) the second lowest cost silver plan premium that would have been in place without the waiver in place for the plan year to (2) the second lowest cost silver plan in place with the waiver in place for the plan year, as determined for the purposes of calculating the section 1332 waiver pass-through payment.[26] This factor will be calculated specific to each State and geographic area, to the extent that the factor may vary across geographic areas. The second lowest cost silver plan premiums with and without the waiver, as provided by the State as part of the section 1332 waiver information submitted to the Secretaries, will be reviewed by CMS and used to calculate the factor. In the event that the State's section 1332 waiver second lowest cost silver plan with- and without-waiver information is not available prior to the calculation of the Federal BHP payments in the

[26] Office of Tax Analysis, Department of Treasury, "Method for Calculation of Section 1332 Reinsurance Waiver 2021 Premium Tax Credit Pass-through Amounts," March 2021.

fall prior to the start of the BHP program year, we are finalizing our proposal to temporarily use values from the prior year's waiver reporting, and then retroactively update the payment rates and payments once the values for the applicable plan year are known. In the case that prior-year data is not available, such as in the case of a new waiver or waiver amendment that could delay the timeline by which the State would receive BHP funding, we are finalizing our proposal to initially calculate the rates without adjustment for the section 1332 WF, and then to retroactively adjust payment rates and payments using the updated waiver data once it becomes available.[27]

E. State Option to Use Prior Program Year QHP Premiums for BHP Payments

In the interest of allowing States greater certainty in the total BHP Federal payments for a given plan year, we have given States the option to have their final Federal BHP payment rates calculated using a projected adjusted reference premium (that is, using premium data from the prior program year multiplied by the premium trend factor (PTF), as described in Equation (2b)). We will require States to make their election to have their final Federal BHP payment rates calculated using a projected adjusted reference premium by 60 days after the publication of this final rule.

With the addition of the section 1332 WF, there is the possibility that using the previous year's QHP premiums multiplied by the PTF could lead to unexpected results if there are significant changes to the State's approved section 1332 waiver, including changes that could occur at the start or the end of the waiver. For example, if a State were to implement a section 1332 waiver in 2023 that lowered premiums significantly, and the State then chose to use the prior year's premiums (that is, 2022 plan year premiums) multiplied by the PTF, this could lead to BHP payment well in excess of what would have been paid in the Exchanges when the WF is added to the methodology. Similarly, if a State were to end its section 1332 waiver and choose to use the prior year's premiums, the BHP payment could be less than what would otherwise be expected.

[27] 42 CFR 600.610(c)(2)(iii).

We are finalizing our proposal that in the following cases, the current year QHP premiums would have to be used for calculating BHP payments with regard to section 1332 waivers: (1) A State implements a new section 1332 waiver that begins at the start of the BHP program year; (2) a State ends a section 1332 waiver in the year prior to the start of the BHP program year; or (3) the percentage difference between the with and without waiver premiums used to determine the section 1332 waiver pass-through funding amount (and used to determine the WF) changes by 5 or more percentage points from the prior year. The percentage difference would be measured based on the enrollment-weighted average of the with and without waiver premiums. We believe that these three scenarios (the start of a new waiver, the end of a waiver, and a significant change to a waiver) reflect all relevant scenarios in which changes to a section 1332 waiver would lead to a significant error in the calculation of BHP payments if the prior year premiums were used in the BHP payment methodology. We believe that the requirement to use the current year QHP premiums in these limited circumstances would avoid an incorrect calculation of BHP payments due to changes related to the section 1332 waiver.

For Equation (2b), we will define the PTF, with minor changes in calculation sources and methods, as follows:

PTF: In the case of a State that would elect to use the 2022 premiums as the basis for determining the 2023 BHP payment, it would be appropriate to apply a factor that would account for the change in health care costs between the year of the premium data and the BHP program year. This factor would approximate the change in health care costs per enrollee, which would include, but not be limited to, changes in the price of health care services and changes in the utilization of health care services. This would provide an estimate of the adjusted monthly premium for the applicable second lowest cost silver plan that would be more accurate and reflective of health care costs in the BHP program year.

For the PTF we are finalizing our proposal to use the annual growth rate in private health insurance expenditures per enrollee from the National Health Expenditure (NHE) projections,

developed by the Office of the Actuary in CMS (https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected). Based on these projections, we are finalizing our proposal that the PTF be 4.6 percent for BHP program year 2023.

We note that the increase in premiums for QHPs from 1 year to the next may differ from the PTF developed for the BHP funding methodology for several reasons. In particular, we note that the second lowest cost silver plan may be different from 1 year to the next. This may lead to the PTF being greater than or less than the actual change in the premium of the second lowest cost silver plan.

F. State Option to Include Retrospective State-Specific Health Risk Adjustment in Certified Methodology

To determine whether the potential difference in health status between BHP enrollees and consumers in an Exchange would affect the PTC and risk adjustment payments that would have otherwise been made had BHP enrollees been enrolled in coverage through an Exchange, we will provide States implementing the BHP the option to propose and to implement, as part of the certified methodology, a retrospective adjustment to the Federal BHP payments to reflect the actual value that would be assigned to the population health factor (or risk adjustment) based on data accumulated during that program year for each rate cell.

We acknowledge that there is uncertainty for this factor due to the lack of available data to analyze potential health differences between the BHP and QHP populations, which is why, absent a State election, we are finalizing our proposal to use a value for the PHF (see section III.D.3. of this final rule) to determine a prospective payment rate which assumes no difference in the health status of BHP enrollees and QHP enrollees. There is considerable uncertainty regarding whether the BHP enrollees will pose a greater risk or a lesser risk compared to the QHP enrollees, how to best measure such risk, the potential effect such risk would have had on

PTC, and risk adjustment that would have otherwise been made had BHP enrollees been enrolled in coverage through an Exchange. However, to the extent that a State would develop an approved protocol to collect data and effectively measure the relative risk and the effect on Federal payments of PTCs and CSRs, we are finalizing our proposal to permit a retrospective adjustment that will measure the actual difference in risk between the two populations to be incorporated into the certified BHP payment methodology and used to adjust payments in the previous year.

For a State electing the option to implement a retrospective population health status adjustment as part of the BHP payment methodology applicable to the State, we are finalizing our proposal to require the State to submit a proposed protocol to CMS, which would be subject to approval by us and would be required to be certified by the Chief Actuary of CMS, in consultation with the OTA. We are finalizing our proposal to apply the same protocol for the population health status adjustment as what is set forth in guidance in "Considerations for Health Risk Adjustment in the Basic Health Program in Program Year 2015" (https://www.medicaid.gov/sites/default/files/2019-11/risk-adjustment-and-bhp-white-paper.pdf). We proposed to require a State to submit its proposed protocol for the 2022 program year by the later of August 1, 2022 or 60 days after the publication of this final rule. Because this final rule is being published within 60 days of August 1, 2022, we are finalizing that a State will be required to submit its proposed protocol for the 2022 program year by 60 days after the publication of this final rule. This submission will also need to include descriptions of how the State would collect the necessary data to determine the adjustment, including any contracting contingences that may be in place with participating standard health plan issuers. We will provide technical assistance to States as they develop their protocols, as requested. We proposed that we must approve the State's protocol by December 31, 2022, for the 2023 program year. Due to the publication date of this final rule, we are finalizing that we will approve the State's protocol within 50 days of receipt of the proposed protocol. Finally, the State will be required to

complete the population health status adjustment at the end of the program year based on the approved protocol. After the end of the program year, and once data is made available, we will review the State's findings, consistent with the approved protocol, and make any necessary adjustments to the State's Federal BHP payment amounts. If we determine the Federal BHP payments were less than they would have been using the final adjustment factor, we will apply the difference to the State's next quarterly BHP trust fund deposit. If we determine that the Federal BHP payments were more than they would have been using the final reconciled factor, we will subtract the difference from the next quarterly BHP payment to the State.

IV. Revisions to Basic Health Program Regulations

We proposed two changes related to the timing of publication of the BHP payment methodologies under 42 CFR 600.610. Specifically, we proposed to revise § 600.610(a)(1) to provide for issuance of payment notices that may be effective for only one or multiple program years, as determined by and subject to the discretion of the Secretary, beginning with the 2023 BHP payment methodology and then going forward. In addition, we proposed at § 600.610(a)(1) and (b)(1) to change the schedule of publication dates for the proposed and final BHP payment notices. As stated in section II.H. of this final rule, we received several comments in support of these proposed changes. Therefore, we are finalizing these regulations as proposed, with minor formatting edits to separate § 600.610(a)(1) into § 600.610(a)(1)(i) and (ii) for increased clarity.

We also proposed to revise § 600.610(c)(2)(ii) such that a State's payment amount may be retroactively revised due to a mathematical error in the development or application of the BHP funding methodology. We discussed that CMS recently became aware of an error in calculating the IRF for program year 2019, resulting in an underpayment of Federal funds to States for their BHPs. In reviewing the model used to calculate the IRF, CMS and OTA found an error in the computation of the IRF. Working with OTA, we developed a new value for the IRF for 2019. Previously, the IRF for the 2019 BHP payment methodology was 98.03 percent. The corrected value for the IRF for program year 2019 was recalculated as the median of the impact

of income reconciliation on PTC for persons with incomes between 100 percent and 200 percent of FPL (102.36 percent) and the impact for persons with incomes between 133 percent and 200 percent of FPL (101.66 percent), which is 102.01 percent. Using the median of the two values is the same approach as we used to calculate the original IRF value in 2019, and the difference between the values is attributable to a mathematical error made during the development of the BHP payment methodology for program year 2019. As stated in section II.H. of this final rule, we received comments in support of this regulation change, which would also allow us to issue corrected payments to states for 2019. We are finalizing this regulation change as proposed. We will issue further guidance to states on the timing of receiving the updated payments for 2019.

V. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3501 et seq.), we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a "collection of information" requirement is submitted to the Office of Management and Budget (OMB) for review and approval. For the purpose of the PRA and this section of the preamble, collection of information is defined under 5 CFR 1320.3(c) of the PRA's implementing regulations.

To fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the PRA requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

In the May 25, 2022 BHP proposed rule (87 FR 31815), we solicited public comment on each of these issues for that rule's proposed collection of information requirements and burden

estimates. We did not receive such comments and are finalizing those requirements and burden estimates as proposed. The finalized requirements and burden estimates follow.

A. Wage Estimates

To derive average costs, we used data from the U.S. Bureau of Labor Statistics' (BLS) May 2021 National Occupational Employment and Wage Estimates for our salary estimates (https://www.bls.gov/oes/current/oes_nat.htm). In this regard, Table 2 presents BLS' mean hourly wage, our estimated cost of fringe benefits and overhead, and our adjusted hourly wage.

TABLE 2: National Occupational Employment and Wage Estimates

Occupation Title	Occupation Code	Mean Hourly Wage ($/hr)	Fringe Benefits and Overhead ($/hr)	Adjusted Hourly Wage ($/hr)
Business Operations Specialists	13-1000	38.64	38.64	77.25
General and Operations Managers	11-1021	55.41	55.41	110.82

To derive the average cost estimates, we also adjusted BLS' mean hourly wage by a factor of 100 percent. This is necessarily a rough adjustment, both because fringe benefits and overhead costs vary significantly from employer to employer, and because methods of estimating these costs vary widely from study to study. Therefore, we believe that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method.

B. Information Collection Requirements (ICRs)

When ready, the following changes will be submitted to OMB for approval under control number 0938-1218 (CMS-10510). Consistent with the May 25, 2022 (87 FR 31815) proposed rule, we are in the process of reinstating that control number as our previous approval was discontinued on August 31, 2017, based on our estimated number of respondents. We are reinstating the control number based on 5 CFR 1320.3(c)(4)(i) using the standard non-rule PRA process which includes the publication of 60- and 30-day **Federal Register** notices. In addition to the reinstatement, we are also in the process of proposing changes that are associated with the March 12, 2014 (79 FR 14112) BHP final rule that have not previously received PRA approval. The following finalized burden estimates are also included in our reinstatement effort. The 60-

day notice published in the **Federal Register** on August 4, 2022 (87 FR 47750). The collection of information request will be submitted to OMB for approval subsequent to the publication of the 30-day **Federal Register** notice.

1. ICRs Regarding the Submission of Estimated and Actual Quarterly Enrollment Data

In sections II.A. and III.B. of this final rule, we finalized that a State that is approved to implement a BHP must provide CMS with an estimate of the number of BHP enrollees its projects will enroll in the upcoming BHP program quarter, by applicable rate cell, prior to the first quarter and each subsequent quarter of program operations until after actual enrollment data is available. Enrollment data must be submitted by age range (if applicable), geographic area, coverage status, household size, and income range.

We estimate that it will take a business operations specialist 10 hours at $77.25/hr and a general manager 2 hours at $110.82/hr to compile and submit the quarterly estimated enrollment data to CMS. For 2023, we estimate that two States will operate a BHP and will submit the required estimated enrollment data to CMS. In aggregate, we estimate an annual burden of 96 hours (2 States x 12 hr/response x 4 responses/yr) at a cost of $7,953 [2 States x 4 responses/yr ((10 hr x $77.25/hr) + (2 hr x $110.82/hr)).

In sections II.A. and III.B. of this final rule, we also finalized that, following each BHP program quarter, a State operating a BHP must submit actual enrollment data to CMS. Actual enrollment data must be based on individuals enrolled for the quarter who the State found eligible and whose eligibility was verified using eligibility and verification requirements as agreed to by the State in its applicable BHP Blueprint for the quarter that enrollment data is submitted. Actual enrollment data must include a personal identifier, date of birth, county of residence, Indian status, family size, household income, number of persons in the household enrolled in BHP, family identifier, months of coverage, plan information, and any other data required by CMS to properly calculate the payment. This may include the collection of data related to eligibility for other coverage, marital status (for calculating household composition), or

more precise residence location.

We estimate that it will take a business operations specialist 100 hours at $77.25/hr and a general manager 10 hours at $110.82/hr to compile and submit the quarterly actual enrollment data to CMS. For 2023, we estimate that two States will operate a BHP and will submit the required actual enrollment data to CMS. In aggregate, we estimate an annual burden of 880 hours (2 States x 110 hr/response x 4 responses/yr) at a cost of $70,666 [2 States x 4 responses/yr ((100 hr x $77.25/hr) + (10 hr x $110.82/hr)).

2. ICRs Regarding Submission of Qualified Health Plan Data

In section III.C. of this final rule, we finalized that States operating an SBE in the individual market must provide certain data, including premiums for second lowest cost silver plans, by geographic area, for CMS to calculate the Federal BHP payment rates in those States. We proposed that States operating BHPs interested in obtaining the applicable 2023 program year Federal BHP payment rates for its State must submit the data to CMS by October 15, 2022. Because we are finalizing this rule after October 15, 2022, we have changed the submission deadline from "October 15, 2022" to read "within 30 days of publication of this final rule."

We estimate that it will take a business operations specialist 20 hours at $77.25/hr and a general manager 2 hours at $110.82/hr to compile and submit the required data to CMS. In aggregate, we estimate an annual burden of 44 hours (2 States x 22 hr/response) at a cost of $3,533 [2 States x ((20 hr x $77.25/hr) + (2 hr x $110.82/hr))].

C. Summary of Requirements and Annual Burden Estimates

TABLE 3: Summary of Requirements and Annual Burden Estimates

Section under Title 42 of the CFR	OMB Control No. (CMS ID No.)	# of Respondents	Total Responses	Time per Response (hr)	Total Time (hr)	Labor Cost ($/hr)	Total Cost ($)
600.610 (projected number of BHP enrollees)	0938-1218 (CMS-10510)	2	8	12	96	Varies	7,953
600.610 (actual number of BHP enrollees)	0938-1218 (CMS-10510)	2	8	110	880	Varies	70,666
600.610 (qualified health plan data)	0938-1218 (CMS-10510)	2	2	22	44	Varies	3,533
TOTAL		**2**	**18**	**Varies**	**1,020**	**Varies**	**82,152**

VI. Regulatory Impact Analysis

A. Statement of Need

Section 1331 of the ACA (42 U.S.C. 18051) requires the Secretary to establish a BHP, and section 1331(d)(1) specifically provides that if the Secretary finds that a State meets the requirements of the program established under section 1331(a) of the ACA, the Secretary shall transfer to the State Federal BHP payments described in section 1331(d)(3) of the ACA. This final rule provides for the funding methodology to determine the Federal BHP payment amounts required to implement these provisions for program year 2023.

B. Overall Impact

We have examined the impacts of this rule as required by E.O. 12866 on Regulatory Planning and Review (September 30, 1993), E.O. 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA) (Pub. L. 96354, enacted September 19, 1980), section 1102(b) of the Act, section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104-4, enacted March 22, 1995), E.O. 13132 on Federalism (August 4, 1999), and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Section 3(f) of Executive Order 12866 defines a "significant regulatory action" as an action that is likely to result in a rule: (1) (having an annual effect on the economy of $100 million or more in any 1 year, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local or tribal governments or communities (also referred to as "economically significant"); (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive order.

A regulatory impact analysis (RIA) must be prepared for major rules with significant regulatory action(s) or with economically significant effects ($100 million or more in any 1 year). Based on our estimates, OMB's Office of Information and Regulatory Affairs has determined this rulemaking is "economically significant" as measured by the $100 million threshold. Accordingly, we have prepared a Regulatory Impact Analysis that to the best of our ability presents the costs and benefits of the rulemaking.

C. Detailed Economic Analysis

The aggregate economic impact of this final payment methodology is estimated to be $357 million in transfers for calendar years (CY) 2022 and 2023 (measured in real 2022 dollars), which would be an increase in Federal payments to the State BHPs. For the purposes of this analysis, we have assumed that two States would implement BHPs in 2023. This assumption is based on the fact that two States have established a BHP to date, and we do not have any indication that additional States may implement a BHP in CY 2023. Of these two States, only

one (Minnesota) currently has an approved section 1332 waiver.

Projected BHP enrollment and expenditures under the previous payment methodology were calculated using the most recent 2022 QHP premiums and State estimates for BHP enrollment. We projected enrollment for 2023 using the projected increase in the number of adults in the U.S. from 2022 to 2023 (0.4 percent), and we projected premiums using the NHE projection of premiums for private health insurance (4.6 percent). Prior to any changes made in the 2023 BHP payment methodology, Federal BHP expenditures are projected to be $8,340 million in 2023, which are described in detail below. This projection serves as our baseline scenario when estimating the net impact of the 2023 methodology on Federal BHP expenditures.

The incorporation of the WF is the most significant change in this final 2023 payment methodology from the final 2022 payment methodology. To calculate the impact of adding the WF to the methodology, we took the following steps. First, we calculated the estimated value of the WF using the most recently available section 1332 waiver premium data for 2021.[28] In Minnesota, the average percentage difference between the "with waiver" second lowest cost silver plan premiums and the "without waiver" second lowest cost silver plan premiums for 2021 is 27.3 percent (calculated as the average of the "without waiver" second lowest cost silver plan premium divided by the "with waiver" second lowest cost silver plan premium, averaged across all rating areas). We then increased the RPs in the model for Minnesota by 27.3 percent, which represents the impact of the WF. The resulting Federal BHP payments were 28.2 percent higher incorporating this adjustment. The projected BHP expenditures after these changes are $8,154 million, which is the sum of the prior estimate ($8,021 million) and the impacts of the changes to the methodology ($133 million). For Minnesota, estimated payments would increase from $470 million to $603 million in 2023.

[28] https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/1332-State-Specific-Premium-Data-Feb-2021.xlsx.

TABLE 4: Estimated Federal Impacts for the Basic Health Program 2023 Payment Methodology (Millions of 2022 dollars)

Projected Federal BHP Payments under 2022 Final Methodology	$8,021
Projected Federal BHP Payment under 2023 Final Methodology	$8,154
Federal costs	$133
Totals may not add due to rounding	

The provisions of this final methodology are designed to determine the amount of funds that will be transferred to States offering coverage through a BHP rather than to individuals eligible for Federal financial assistance for coverage purchased on the Exchange. We are uncertain what the total Federal BHP payment amounts to States will be as these amounts will vary from State to State due to the State-specific factors and conditions. In this case, the exact value of the WF and the effects of the section 1332 waiver in 2023 are currently unknown. The value of the WF could be higher or lower than estimated here as a result. In addition, projected BHP expenditures and enrollment may also differ from our current estimates, which may also lead to costs being higher or lower than estimated here.

In addition, the final methodology will allow for a retrospective correction to the BHP payment methodology for errors that occurred during the development or application of the BHP funding methodology. For 2019, we are finalizing our proposal to correct the value of the IRF from 98.03 percent to 102.01 percent. Actual Federal BHP expenditures in 2019 were $5,591 million, including payment reconciliations that have occurred as of March 2022. Calculating the payments with the corrected IRF value increases the payments by about $224 million. The actual amount may differ as we continue to reconcile 2019 payments based on actual enrollment.

TABLE 5: Estimated Federal Impacts for the Basic Health Program 2023 Payment Methodology to Apply Retrospective Corrections (Millions of 2022 dollars)

Projected Federal BHP Payments under 2022 Final Methodology	$5,591
Projected Federal BHP Payment under 2023 Final Methodology	$5,815
Federal costs	$224
Totals may not add due to rounding	

The total estimated impact of this final methodology is $357 million ($133 million for the addition of the section 1332 waiver factor, and $224 million for the correction to the income reconciliation factor for 2019).

D. Alternative Approaches

We considered several alternatives in developing the BHP payment methodology for 2023, and we discuss some of these alternatives below.

We considered alternatives as to how to calculate the PAF in the final methodology for 2023. The value for the PAF is 1.188, which is the same as was used for 2018 through 2022. We believe it would be difficult to obtain the updated information from QHP issuers comparable to what was used to develop the 2018 factor, because QHP issuers may not distinctly consider the impact of the discontinuance of CSR payments on the QHP premiums any longer. We do not have reason to believe that the value of the PAF would change significantly between program years 2018 and 2023. We are continuing to consider whether or not there are other methodologies or data sources we may be able to use to calculate the PAF.

We also considered alternatives as how to calculate the MTSF in the final methodology for 2023. Given the changes made to the determination of PTC for 2022 in the ARP, we are not including the MTSF in the 2023 payment methodology, as described in section III.D.6. of this final rule.

We also considered whether to continue to provide States the option to develop a protocol for a retrospective adjustment to the PHF as we did in previous payment methodologies. We believe that continuing to provide this option is appropriate and likely to improve the accuracy of the final payments.

We also considered whether to require the use of the program year premiums to develop the Federal BHP payment rates, rather than allow the choice between the program year premiums and the prior year premiums trended forward. We believe that the payment rates can

still be developed accurately using either the prior year QHP premiums or the current program year premiums and that it is appropriate to continue to provide the States these options.

We also considered whether or not to include a factor to address the impacts of State Innovation Waivers. In previous methodologies, we have not addressed the potential impacts of State Innovation Waivers on BHP payments. We believe it is appropriate to include such a factor for this payment methodology. We also considered other approaches to calculating the factor, including whether or not to use each State's experience separately or to look at the impacts across all States. We believe it is more accurate to use each State's experience separately, as applicable.

Many of the factors in this final methodology are specified in statute; therefore, for these factors we are limited in the alternative approaches we could consider. We do have some choices in selecting the data sources used to determine the factors included in the methodology. Except for State-specific RPs and enrollment data, we will use national rather than State-specific data. This is due to the lack of currently available State-specific data needed to develop the majority of the factors included in the methodology. We believe the national data will produce sufficiently accurate determinations of payment rates. In addition, we believe that this approach will be less burdensome on States. In many cases, using State-specific data would necessitate additional requirements on the States to collect, validate, and report data to CMS. By using national data, we are able to collect data from other sources and limit the burden placed on the States. For RPs and enrollment data, we will use State-specific data rather than national data, as we believe State-specific data will produce more accurate determinations than national averages. Our responses to public comments on these alternative approaches are in section II of this final rule.

E. Accounting Statement and Table

In accordance with OMB Circular A-4, Table 6 depicts an accounting statement summarizing the assessment of the transfers associated with these payment methodologies.

TABLE 6: Accounting Statement: Federal Transfers to States
[$ millions]

Category	Primary estimate	Low estimate	High estimate	Units		
				Year dollar	Discount rate (%)	Period Covered
Annualized monetized transfers	$180	$163	$197	2022	7	2022-2023
from Federal government to States	$179	$162	$196	2022	3	2022-2023

As required by OMB Circular A-4 (available at https://www.whitehouse.gov/wp-content/uploads/legacy_drupal_files/omb/circulars/A4/a-4.pdf), we have prepared an accounting statement in Table 6 showing the classification of the transfer payments from the Federal Government to States associated with the provisions of this final rule. Table 6 provides our best estimates of the transfer payments outlined in the section IV.C. of this final rule. These estimates assume that costs in 2022 could be 5 percent above and below the primary estimate (from $212 million to $235 million in 2022 dollars) and that costs in 2023 could be 18 percent above and below the primary estimate ($109 million to $156 million in 2022 dollars, which reflects a waiver factor that could be 5 percentage points higher or lower than assumed in the analysis).

F. Regulatory Flexibility Act (RFA)

The Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*) (RFA) requires agencies to analyze options for regulatory relief of small entities, if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, we estimate that no small entities will be impacted as that term is used in the RFA (include small businesses, nonprofit organizations, and small governmental jurisdictions). The great majority of hospitals and most other health care providers and suppliers are small entities, either by being nonprofit organizations or by meeting the Small Business Administration definition of a small business (having revenues of less than $8.0 million to $41.5 million). Individuals and States are not included in the definition of a small entity. As its measure of significant economic impact on a substantial number of small entities, HHS uses a change in revenue of more than 3 to 5 percent. We do not believe that this threshold will be reached by the requirements in this final rule.

Because this methodology is focused solely on Federal BHP payment rates to States, it does not contain provisions that would have a direct impact on hospitals, physicians, and other health care providers that are designated as small entities under the RFA. Accordingly, we have determined that the methodology, like the previous methodology and the final rule that established the BHP program, will not have a significant economic impact on a substantial number of small entities. Therefore, the Secretary has determined that this rule will not have a significant economic impact on a substantial number of small entities.

Section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a methodology may have a significant economic impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a metropolitan statistical area and has fewer than 100 beds. For the preceding reasons, we have determined that the methodology will not have a significant impact on a substantial number of small rural hospitals. Therefore, the Secretary has determined that this final rule will not have a significant impact on the operations of a substantial number of small rural hospitals.

G. Unfunded Mandates Reform Act (UMRA)

Section 202 of the Unfunded Mandates Reform Act (UMRA) of 1995 requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation, by State, local, or tribal governments, in the aggregate, or by the private sector. In 2022, that threshold is approximately $165 million. States have the option, but are not required, to establish a BHP. Further, the methodology would establish Federal payment rates without requiring States to provide the Secretary with any data not already required by other provisions of the ACA or its implementing regulations. Thus, the final payment methodology does not mandate expenditures by State governments, local governments, or tribal governments.

H. Federalism

E.O. 13132 establishes certain requirements that an agency must meet when it issues a final rule that imposes substantial direct effects on States, preempts State law, or otherwise has federalism implications. The BHP is entirely optional for States, and if implemented in a State, provides access to a pool of funding that would not otherwise be available to the State. Accordingly, the requirements of E.O. 13132 do not apply to this final rule.

I. Conclusion

We believe that this final BHP payment methodology is effectively the same methodology as finalized for 2022, with the exception of the addition of the WF. In addition, we are finalizing the proposal to update the regulation to clarify that errors in the application and the development of the methodology may be corrected retroactively. BHP payment rates may change as the values of the factors change, most notably the QHP premiums for 2022 or 2023. We do not anticipate this final methodology to have any significant effect on BHP enrollment in 2023.

In accordance with the provisions of E.O. 12866, this regulation was reviewed by the Office of Management and Budget.

Chiquita Brooks-LaSure, Administrator of the Centers for Medicare & Medicaid Services, approved this document on November 23, 2022.

List of Subjects in 42 CFR Part 600

Administrative practice and procedure, Health care, Health insurance, Intergovernmental relations, Penalties, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services amends 42 CFR part 600 as set forth below:

PART 600—ADMINISTRATION, ELIGIBILITY, ESSENTIAL HEALTH BENEFITS, PERFORMANCE STANDARDS, SERVICE DELIVERY REQUIREMENTS, PREMIUM AND COST SHARING, ALLOTMENTS, AND RECONCILIATION

1. The authority citation for part 600 continues to read as follows:

Authority: Section 1331 of the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148, 124 Stat. 119), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152, 124 Stat 1029).

2. Amend § 600.610—

a. By revising paragraphs (a)(1) and (b)(1); and

b. In paragraph (c)(2)(ii) by removing the phrase “during the application of the BHP funding methodology” and adding in its place the phrase “during the application or development of the BHP funding methodology”.

The revisions read as follows:

§ 600.610 Secretarial determination of BHP payment amount.

(a) * * *

(1) Beginning in FY 2015, the Secretary will determine and publish in a **Federal Register** document the BHP payment methodology for the next calendar year or, beginning in calendar year 2022, for multiple calendar years. Beginning in calendar year 2023 –

(i) In years in which the Secretary does not publish a new BHP methodology, the Secretary will update the values of factors needed to calculate the Federal BHP payments via sub regulatory guidance, as appropriate.

(ii) In years that the Secretary publishes a revised payment methodology, the Secretary will publish a proposed BHP payment methodology upon receiving certification from the Chief Actuary of CMS.

* * * * *

(b) * * *

(1) Beginning in calendar year 2023, in years that the Secretary publishes a revised payment methodology, the Secretary will determine and publish the final BHP payment methodology and BHP payment amounts in a **Federal Register** document.

* * * * *

Dated: December 12, 2022.

Xavier Becerra,

Secretary,

Department of Health and Human Services.

[FR Doc. 2022-27211 Filed: 12/16/2022 11:15 am; Publication Date: 12/20/2022]